Quality Health for Manitobans
The Action Plan

A strategy to assure the future of Manitoba's health services system

Manitoba Health

MAY, 1992

CONTENTS

An Introduction from Manitoba's Minister of Health IV

A Message from the Deputy Minister of Health for Manitoba VII

PART ONE:

A Vision for the Future of Manitoba's Health Services System 1

The Characteristics of The Vision 2

PART TWO:

The Foundations for Re-structuring Manitoba's Health Services System 5

Major Determinants of Health 9

THE FIRST FOUNDATION:
Developing a Broad Government Focus on "Healthy Public Policy" 10

THE SECOND FOUNDATION:
Building a "Partnership for Health" in Manitoba 11

THE THIRD FOUNDATION:
Building and Managing a Full Continuum of Health Services for Manitobans 12

THE FOURTH FOUNDATION:
Developing a Government Organization Capable of Managing Change and Improvement in Health Services for Manitobans 16

THE FIFTH FOUNDATION:
Building the Capacity to Systematically Monitor and Evaluate the Quality, Appropriateness, Effectiveness and Outcomes of Manitoba Health Services 17

PART THREE:
Quality Health for Manitobans - The Action Plan 19

Priority Action:
Community-Oriented Health Services Development Strategy 21

Priority Action:
Broadening the Partnership with Community Health Centres 24

Priority Action: Hospital System Reform 24

Priority Action: Public Education/Patient Empowerment Strategy 42

Priority Action: Physician Human Resource Plan and Allocation 46

Priority Action: Systemic Cost-Driver Reforms 54

Priority Action: Nursing Resource Policy Development 57

Priority Action: Technology Assessment and Management 60

Priority Action: Provincial Health Information Strategy 64

CONCLUSION 64

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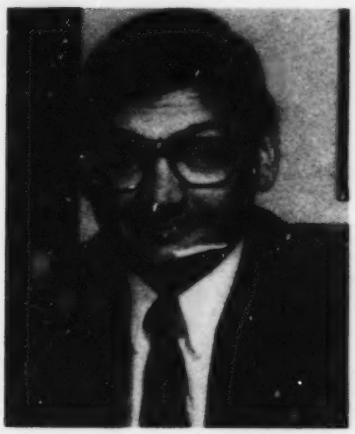


An Introduction from Manitoba's Minister of Health

One of the fundamental values that unites us as Manitobans and Canadians is a commitment to the health and well being of all of our citizens. The five principles of medicare (universality, accessibility, comprehensiveness, portability and public administration) are a reflection of that commitment. At the Ministers' of Health Conference in Winnipeg last fall, all Health Ministers committed to the principles of the Canadian health system, to effective management of the system, and to the assurance of adequate funding through dialogue with the Federal Government.

In March of this year, a joint statement was issued by the First Ministers which included the following:

"First Ministers directed Health Ministers to initiate work to apply the broad principles of the Canadian health care system to the objectives of sustainability, affordability, flexibility, responsiveness and effectiveness of the system, funded without destabilizing provincial and federal finances."

When I became minister of Health four years ago, I recognized that Manitoba's (and Canada's) health services system requires fundamental restructuring if we are to preserve the principles of medicare. Every Province and Territory in Canada is facing the same challenge - health costs and services are rising at a faster rate than either population growth or the rate of inflation - and there is little scientific evidence that rising costs or increases in the resources devoted to illness care have made an appreciable difference to the health status of Manitobans.

My first and foremost consideration is to protect the health and well being of Manitobans and the interests of patients, as the government begins the restructuring of our health services system to assure its future. Greater wellness, better quality of life, reduced disability and care that is closer to home will be my measure of the health outcome of our medical treatment and services.

Although health care funding from the federal government remains a primary concern, it is not simply a question of more money for the system. **The government will not introduce user fees.** User fees do nothing to encourage effective utilization of health services and they may serve as a barrier to needed services for some people. It is a question of managing our health dollars better. We need to achieve a better balance between institutional and community oriented services and we need to ensure that all of our health services meet the needs of Manitobans in terms of improvement to their health.

There really are two fundamental problems in health services today - a cost problem and a quality/knowledge problem. **The need is not to reduce health spending - but to contain the rate of growth in these costs.** Neither Manitoba nor any other province in Canada can afford to permit health service costs to continue to escalate at the rates that we have seen in recent years. If we do, it will become literally beyond our financial capacity to pay for health services and the system will deteriorate.

We know that many of the determinants of health go beyond the health services system. Socioeconomic status, the environment, lifestyle, genetic endowment and the productivity and wealth of the society as a whole are all key factors in determining the health of Manitobans. Any dollar spent unnecessarily in health services is a dollar that is not available - be it for other health services or for other obligations of government. **At the same time, there will be no compromise on the fundamental concept of Medicare.**

Experience in other industrialized countries where lower cost health service systems result in comparable or better health for their populations makes it clear that - if we have the will and wisdom - we can develop health services that are better as well as being more affordable.

And while costs are a concern, we have an urgent need for the evaluative tools to guide us as we develop a more diverse array of services to achieve better health for Manitobans without uncontrolled spending.

Those who work in Manitoba's health services system have responded responsibly to this challenge but, without an overall action plan and effective means of measuring outcomes, their efforts to improve services while containing costs can never succeed. Manitoba's Action Plan for Quality Health provides that overall plan and the scientific medical measurement systems that we need.

The strategic direction of the health services system will shape all aspects of the system including the capital program. Hospitals will be replaced and upgraded in response to health system objectives which are set within a Healthy Public Policy framework. This new way of doing business will be evident when the 1992/93 Capital Program is announced. The Capital Program in the past has been influenced by the needs of a provincial institutional focus without a comprehensive overview of the health service continuum. The Ministry will be

initiating capital projects where unmet need has been identified and will consider capital projects within the context of the Provincial Health Strategy.

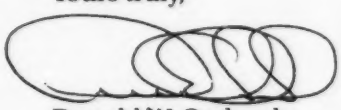
"Quality Health for Manitobans: the Action Plan" lays out the foundations, the vision, and the major elements of the actions we are taking to implement our strategy to assure the future of Manitoba's health services system.

Making the changes that must be made will not be easy. But there is a remarkable degree of agreement among Manitobans - and especially those Manitobans who work within health services. We all believe that we can assure the future of Manitoba's health services system.

We all agree that there is a need for a fundamental shift towards more health promotion, illness prevention and disability postponement and a restructured health services system in which individuals and families have the opportunity to participate in decisions affecting their health. Working together in Manitoba's Partnership for Health - we have laid the foundations for an action plan that will let us do exactly that.

We have prepared this Action Plan to help all Manitobans - including all members of the health system - and all citizens of the province - to become involved in our Partnership. I welcome your comments and suggestions and I ask for your advice and support in the implementation of this plan.

Yours truly,



Donald W. Orchard,
Minister of Health

A Message from
the Deputy Minister of Health
for Manitoba

In the development of "Quality Health for Manitobans - the Action Plan" we have had the benefit of the input, advice, consultation and cooperation of virtually every sector of the health services system including many members of the general public. I offer my sincere thanks to those many people who have contributed both directly and indirectly in the development of the conceptual framework.

One of the most fundamental challenges which faces us as the executive leaders of health services in Manitoba, is the fact that many of the determinants of health are outside the formal system. For example, environmental factors, health and safety in the work place, the impact of economic forces on lifestyles all have a major influence on the health status of Manitobans. As we move to restructure our system, the challenge is to recognize that the health system cannot of itself provide the sole solution but must complement the actions taken in the broader context outside of the formal health care system.

With this in mind, the restructuring of our health services system embodies the following themes:

- **Recognition that health promotion and disease prevention can only be effectively addressed through initiatives and cooperation among a number of government departments and agencies, Manitobans and their families all working collaboratively with the Ministry of Health.**

- **Recognition that services must be provided closer to the communities where people live and work. By bringing together the two solitudes of community oriented and institution oriented services we will bring about a better balance between the two systems. Throughout the change, we must ensure that the interest of the recipients of service is always our top priority.**

- **The introduction of strategies that would provide for the education of Manitobans so as to enable informed choices in order for them to fully participate in the care decisions made by the health care providers.**

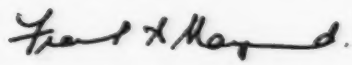
- **The establishment of protocols to evaluate the services that are being provided to ensure they are beneficial to Manitobans.**

- **Recognition by the service providers that their role in the continuum of services may change, thus affording both a challenge and an opportunity for service providers to seek innovative means to protect and enhance the health status of Manitobans..**

- **The allocation of resources to meet the health needs of Manitobans on the basis of cost-effectiveness.**

I am confident that, given the cooperative working relationship between Manitoba **Health** and the health care community, together we will successfully meet the **challenge** to preserve and strengthen Manitoba's health services system.

Yours truly,



Frank A. Maynard,
Deputy Minister of Health

PART ONE:

A Vision for the Future of Manitoba's Health Services System

A Vision (Circa 1924)

"Every city, town and rural municipality should be adequately provided with means for health conservation and health education. The money advanced through the tax rates for such work cannot be used for a better purpose.

Why? Health conservation and health education mean Health Promotion and Disease Prevention. Health Promotion and Disease Prevention are the only means of curtailing the enormous expenditure for the maintenance of institutions for the sick ...."

Elizabeth Russell
Director of Nursing, Manitoba Health
Circa 1924

The **Manitoba Action Plan for Quality Health** is aimed at assuring the future of Manitoba's health services system by restructuring it towards a better balance between prevention, community-oriented and institutional services. The implementation of the plan is based on the development of a "Partnership for Health" involving all of the key stakeholders in the health care system - the community, recipients of service and their families, the broad range of service providers, researchers and government.

The partnership aims to engage all parts of the health services system in a process of change that involves looking at the system as a whole - and at the appropriateness of the various services we provide from the perspective of those Manitobans who need the services.

The Vision (1992)

The "Partnership for Health" involves a clear commitment - and a clear vision - to provide Manitobans with health service alternatives and with more and better information about those alternatives so that individuals can play a full role in decisions about their health and the health services they will receive. **The health status of Manitobans and the interests of service recipients will remain the first and foremost consideration.**

That commitment - and that vision - is reflected in a set of shared goals - goals that have been agreed to by all of the main participants in health services in Manitoba through a broad process of consultation spanning four years of discussions, input and advice from all of the key stakeholders.

Those shared goals are:

The Goals

- ***To improve general health status for all Manitobans***
- ***To reduce inequalities in health status***
- ***To establish public policy which promotes health***
- ***To foster behaviour which promotes health***
- ***To foster environments which promote health***
- ***To provide appropriate, effective and efficient health services***
- ***To develop mechanisms to assess and monitor quality of care, utilization and cost-effectiveness***
- ***To foster responsiveness and flexibility in the health care delivery system***
- ***To promote reasonable public expectations of health care***
- ***To promote delivery of alternative and less expensive services.***

There can be little question that the process of change that is required in Manitoba's health services system will demand goodwill and flexibility from all those who work within health services. But there is general agreement in Manitoba on the main characteristics of the kind of health services system we must build to meet our future needs.

The Characteristics of The Vision

Needs and Outcomes

Manitoba's health services system must be driven by health status needs and health outcomes

The fundamental questions that will be asked within Manitoba's health services system will focus on the needs of individual Manitobans and on the health outcomes our services can help achieve.

The Continuum

Manitoba's health services system must consist of a full continuum of services to respond to individual and community needs

Our health services system must include balanced and integrated programs of prevention, health promotion and community care as well as a full range of appropriate institutional and professional resources including high technology and other resources of scientifically proven efficacy.

Manitoba's health services system must continue to provide Manitobans with access to "effective" health services

Effective Services

Generally speaking, the most appropriate health services will be those that can be delivered closer to home, involving the least possible intervention or loss of independence for the individual, and that can be provided at the lowest total social and financial cost, consistent with the health benefits to the individuals involved.

Within Manitoba's health services system, each element in the system will play a clearly defined and effective role. Preventive or community-oriented support services will have a clear role and will respond to service requirements for which their capabilities are appropriate.

Defined Roles

At the other end of the spectrum, Manitoba's high technology teaching and tertiary hospitals will provide services to those Manitobans who require such services and for whom these facilities can make long term contributions to individual health status.

Within Manitoba's health services system, Manitobans and their families will participate fully in decisions affecting their own health

Participation

Manitobans will be provided with the information they need to make reasoned decisions relating to their own health care in concert with care providers and will have the right and opportunity to make such decisions.

Within Manitoba's health services system, care providers will play a leading role in ensuring that Manitobans receive effective services from the system as a whole

Health Care Providers

Physicians, nurses and other care providers understand the full continuum of services available and will work with Manitobans to choose effective services, and with the health services system as a whole to ensure that there is realistic and timely access to those services.

Within Manitoba's restructured health services system, all major health services, interventions and procedures will be monitored and evaluated in terms of health outcomes.

Monitoring and Evaluation

Wherever possible, ongoing monitoring and evaluation will lead to the development of standards and protocols for health services to ensure that they contribute to improved health status for the people of Manitoba. These standards and protocols will be circulated and used throughout the health services system of the province.

Similarly, any change or reform in health services in Manitoba will be subjected to comprehensive and ongoing evaluation - both prior to the change being undertaken and afterwards - to ensure that they lead to positive health outcomes for Manitobans.

The focus of Manitoba's health services expenditures will reflect the health status needs of Manitobans

Expenditures tied to Health Service Need

The resources the community provides for health services in Manitoba will be allocated to reflect the health service needs of Manitobans based on careful evaluation of health outcomes. This will involve reallocation of resources within the system to ensure that appropriate services are provided for all Manitobans. ***Health services do not exist for the convenience of institutions or service providers: they exist to meet the health needs of Manitobans.***

Manitoba's Action Plan for Quality Health will restructure health services to realize that vision

Restructuring/ Renewal

All of those who have been involved in Manitoba's Partnership for Health subscribe to this vision for Manitoba's health services system. Members of the health services community - from individual practitioners and service providers to our major health care institutions - have been striving, in their own areas of activity, to make that vision a reality.

The Manitoba Action Plan for Quality Health provides an opportunity for us to combine all of those efforts in a process of system-wide renewal and re-structuring that will result in quality and more effective health services for all Manitobans.

PART TWO:

The Foundations for Restructuring Manitoba's Health Services System

A Perspective on the Health Cost Crisis

Action Now

Canadians in all provinces are aware that the costs of our current system of health services are increasing more rapidly than governments' ability to pay those costs without jeopardizing the provision of other essential services.

Fact: more health spending does not equate with improved health or more effective health services... or higher quality of care.

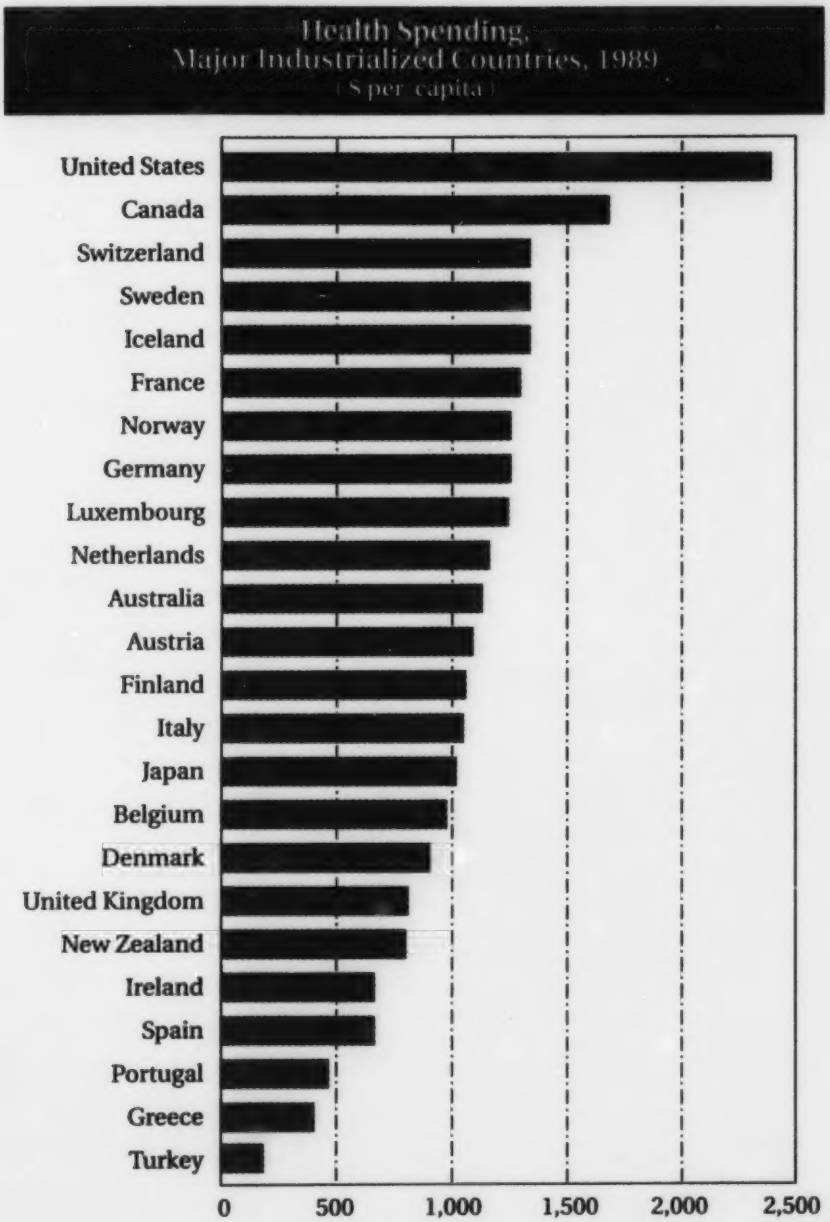
The Impact of More Spending

Manitobans and other Canadians have generally taken it for granted that health care spending is directly related to the quality of health services and to the actual health of our citizens. It was generally assumed that the more we spend, the better services we would provide and the better health our citizens would enjoy. As health costs have continued to escalate in Canada, it has become clear to all of us that this is not necessarily so. The following charts show the total health spending per person in the leading industrialized nations along with two indicators of the health of the people in each country - ***life expectancy and infant mortality.***

Per Capita Health Expenditures, Life Expectancy and Infant Mortality, 1987

	Per Capita	Life Expectancy	Infant Mortality
United States	$2,051	75.0	10.1
Canada	$1,483	76.8	7.3
Sweden	$1,233	77.2	6.1
France	$1,105	77.1	7.8
Germany	$1,093	75.9	7.5
Netherlands	$1,041	77.1	6.8
Japan	$915	78.9	5.0
United Kingdom	$758	75.4	9.0

Note: U.S. dollars
Note: Infant mortality per 1,000 live births
Source:1987/88 O.E.C.D. &World Health Organization data



Note: in U.S. (1989) dollars
Source: Organization for Economic Co-operation and Development, Health Data Bank

On a per capita basis, Canada is the second highest health services spender after the U.S. But - as the two previous charts show - the health of the people in these countries does not appear to vary with the amount of money each spends on health services. Sweden, France and Japan all have higher life expectancies and comparable or lower infant mortality rates than Canada.

Manitoba Health
Expenditure Estimates 1992/93

Service	$ Millions	Percent of total
Hospitals	1016	54.6%
Physicians and other Fees-for-Service	298	16.0%
Personal Care Homes	268	14.4%
Pharmacare	56	3.0%
Sub-total	1638	88.0%
Community Health & Others	223	12.0%
TOTAL	1861	100%

Source: Manitoba Ministry of Health

Just as the levels of spending per person seem to bear little direct relationship to the levels of health of the population as measured by life expectancy or infant mortality, **the numbers of hospital beds or physicians do not necessarily translate into better health.** Yet, in Manitoba, almost 90% of our total health services spending goes to cover the costs of hospitals, physicians services, personal care homes, laboratory tests and drugs. *Overall, provincial health care expenditures will cost $1,800.00 for every man, woman, and child in Manitoba in 1992/93.*

When we compare Canada's experience with that of other industrialized nations, the obvious question is "How do we spend smarter - in a way that will result in quality health outcomes for our people at a price we can afford?"

The Pattern of Manitoba's Health Spending - An Historical Perspective

Why is it that in Canada as a whole and Manitoba in particular we spend more per person on total health care costs and provide more hospital beds in relation to our population than some other countries, even though these expenditures do not necessarily lead to quality health for our people? This pattern of spending reflects the development of government involvement in health services in Manitoba and across Canada.

Health Spending

When Canadians first began to use the financial power of governments to help meet health costs the focus was on the most expensive kinds of health care services - on hospitals and hospital care - the services that most people would find difficult to obtain if they had to pay for these services with "out-of-pocket" income. Manitoba brought in its first universal Hospital Insurance scheme on July 1, 1958, with federal government support. With a few exceptions, such as members of the Canadian Forces, or Royal Canadian Mounted Police, the scheme covered everyone in the province.

On April 1, 1969, Manitoba joined the federal government and the other provinces in adopting Medicare - a universal, government-financed system to ensure that everyone had access to the care of physicians regardless of their personal income or financial status.

The focus of government involvement on hospital and physician costs - and later on personal care homes, prescription drug costs, optometric, chiropractic and a variety of prosthetic and orthotic devices - made perfect sense at that point in time. *Some of these services are essential and they are the highest cost elements in health care* - the elements that individuals and families would most likely be unable to afford without assistance. The Federal/Provincial cooperation in health services made it possible for Canada to develop the sophisticated health care system that we expected as Canadians.

There was, however, an unintended bias within the Federal/Provincial arrangements towards the development and emphasis on the highest cost elements in the overall health services system of Canada. There was also a bias towards geographic centralization of services with expenditures focussed in major urban areas.

Our over-dependence on these higher cost elements of the health services system has been the real driver behind constantly escalating health costs.

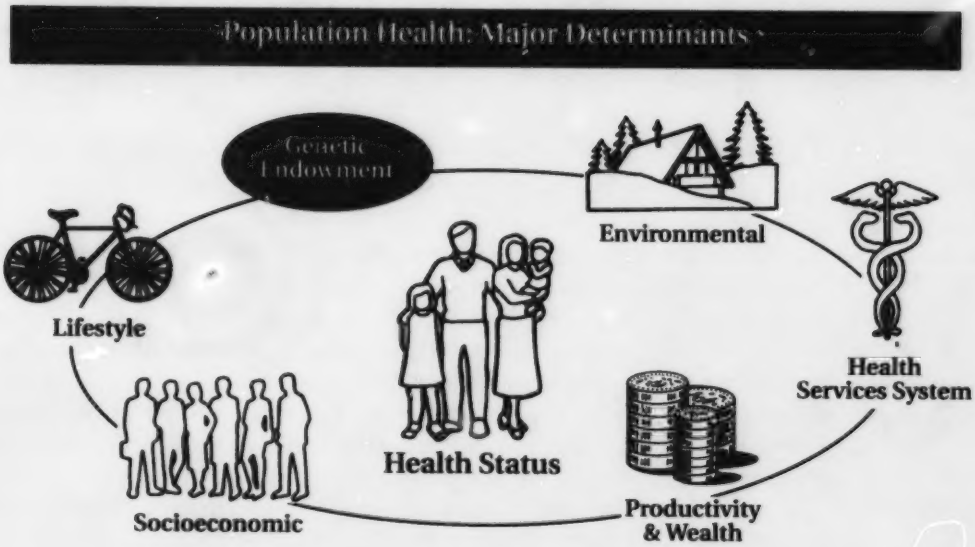
Effective Health Services

Today in Manitoba, with approximately 90% of total health spending focussed on the "illness" institutional model, no one would question this spending if we were confident that it resulted in **effective health services** for all Manitobans and that it returned "value for money" in terms of **improved health for Manitobans**. But - as the uncertain relationship between health spending and actual health in various countries makes clear, that is far from obvious.

Major Determinants of Health

The reason for the differences in health status among countries is that hospitals and physicians are not the main factors that affect the health of a population.

This chart is a graphic representation of the universe of factors that contribute to health.



The **quality and accessibility of the health services system** is one important factor, but international and Canadian research shows that a wide range of other factors also are very strongly associated with the health status of populations.

Health Determinants

Environmental factors - like the availability of pure drinking water, the absence of pollutants or other hazards in the air, soil or the workplace - have direct and significant impacts on health.

Socioeconomic factors - income, housing quality, status in the community, whether or not an individual is employed, whether a person is alone or has family - also have direct impacts on health.

The productivity and wealth of the society as a whole - are directly related to the health of the population: people in richer and more productive societies tend to be healthier than those in poorer ones.

Individual genetic endowment - is an important determinant of health. People from long-lived families tend to live longer. People from families with histories of various diseases may be more susceptible to those diseases.

Lifestyle - has a direct relationship with health. Whether individuals smoke relates directly to their risk of cancer or heart disease. Alcohol or other substance abuse contributes directly to a range of health problems. Eating habits, exercise and stress are all significant contributors to health.

One of the greatest weaknesses of the kind of narrow "hospital/physician" focus that has characterized health services in Canada has been that it has tended to view health in isolation from all of these other factors. We have become proficient in treating some illness, but we have been slow to begin to address these other key determinants of health although they are critical to **preventing illness.**

The First Foundation: Developing a Broad Government Focus on "Healthy Public Policy"

Healthy Public Policy

Manitoba has made a firm commitment to "Healthy Public Policy". Healthy Public Policy focuses on the underlying causes of good or bad health. In simple terms, this commitment means that **every major action and policy of government will be evaluated in terms of its implications for the health of Manitobans.** *The Human Services Committee of Cabinet is responsible for Healthy Public Policy.* In addition to reviewing programs of government to make certain that they contribute to health, Healthy Public Policy also involves broad cooperation among the departments and agencies of government to combat problems that threaten the well-being of Manitobans. The Deputy Ministers' Steering Committee of Health Public Policy serves as the vehicle to implement these policies.

The Healthy Public Policy Programs Division in the reorganized Ministry of Health is mandated to develop this perspective and implement strategies on which it is based.

Substance Abuse Initiative – An Example

For example, Manitoba will launch a major initiative to combat substance abuse in the province - an initiative that involves the educational, law enforcement, health and social services capabilities of government along with a broad coalition of "at risk" populations - youth, aboriginal people, women, and various community groups - in a cooperative effort to curb substance abuse.

This initiative will be complemented by an Alcoholism Foundation of Manitoba pilot project, the **Rural and Northern Youth Intervention Strategy**, which is a school-based awareness, intervention and counselling program targeted at reducing alcohol and other drug use among high school students. This demonstration project will be offered in collaboration with education, social and other health services in the selected communities.

The Healthy Public Policy approach also provides for interdepartmental cooperation to respond to the health and related needs of those at risk. One such cooperative undertaking currently underway involves Manitoba Health

"At Risk" Populations – An Example

and a number of other government departments, along with representatives of a community-oriented agency committed to assisting young women currently involved in street prostitution and those at risk. This three year demonstration project, administered through Mount Carmel Clinic, aims to provide accessible services and alternatives to the young women and girls working as street prostitutes in the downtown core area of Winnipeg. These individuals are at high risk for infection from sexually transmitted diseases, AIDS, other health problems and violence. This group does not normally access traditional services or resources. The interdepartmental and intersectoral collaborative Healthy Public Policy concept demonstrated through this program will ensure more effective health, social, legal and educational services to high risk target groups.

This program aims to assist women to leave prostitution and to prevent young girls and women from becoming involved as street prostitutes by providing realistic and acceptable alternatives. The target group is estimated to number approximately 400 with seasonal fluctuation. It is anticipated that a three year funding commitment of $641,000 will reduce the total costs of health and related government services that these individuals may need if they are left without such services. **The Healthy Public Policy approach enables government to respond more effectively to the needs of such at-risk populations.**

Today we understand that it is not good enough simply to provide physicians and hospitals to care for people once they become ill or disabled. Government has an obligation to work with people to promote health, prevent illness and postpone disability. The Healthy Public Policy approach provides us with a means of meeting that obligation across the whole spectrum of public policy in Manitoba.

Many of the millions of dollars that Manitobans and other Canadians invest each year in treating illness could be used more effectively - and tremendous amounts of human suffering averted - by more effective management of the key determinants of health. That is a challenge not just for governments or health professionals; it is a challenge for each individual and each family in Manitoba.

The Second Foundation: Building a "Partnership for Health" in Manitoba

Health Advisory Network

We have worked to build what we have called Manitoba's "Partnership for Health". There were few mechanisms or fora for broad cross sections of the health services community to work cooperatively - with government and each other. The establishment of the Manitoba Health Advisory Network provided such a forum. The Health Advisory Network engages leading persons from all parts of the health services system in the development of policy recommendations to improve health services and our ability to deliver those services within our financial limits.

Urban Hospital Council

The Urban Hospital Council brought together individuals with executive expertise from all of the hospitals in Winnipeg, including Brandon and Winnipeg Community Health Services, to strive for shared answers to challenges and to ensure effective use of resources.

Regional Mental Health Councils

Regional Mental Health Councils were formed to link all those involved in, and concerned about, mental health services in communities across Manitoba. Additionally, a Provincial Advisory Committee on Mental Health Reform composed of consumer/family representatives, Council Chairpersons and professional representatives, was formed to provide province-wide direction to the reform.

W.I.S.H.

The Westman Integrated Strategy for Health (W.I.S.H.) Project brought together representatives of twenty-three different health care facilities and services in Western Manitoba to explore the potential for better integration of services in that part of the province and to develop a regional model that could be applied across Manitoba.

The principle has been established: all parts of the health services system are being challenged to contribute to better, more effective and affordable health services for Manitobans, and all of the groups in the system are being provided with meaningful opportunities to participate in that process of change and improvement.

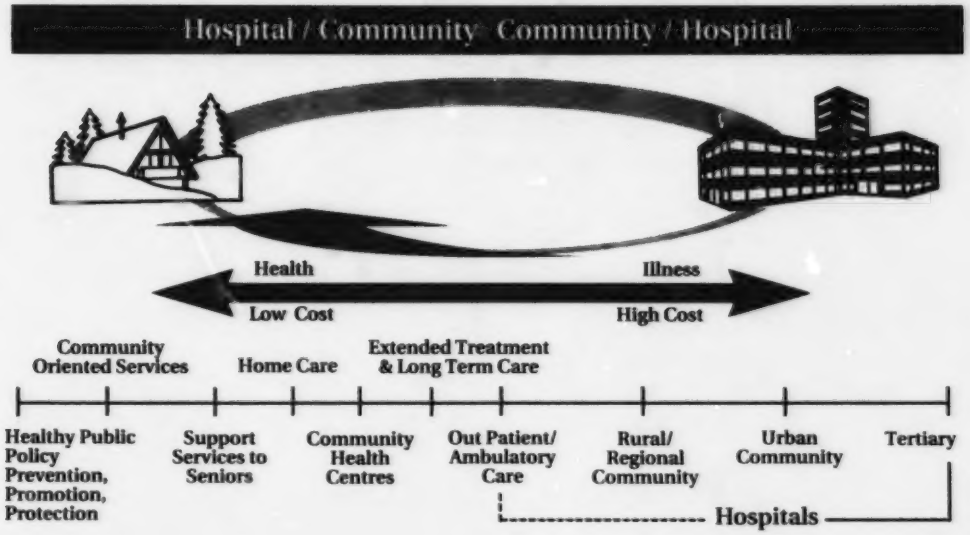
The Third Foundation: Building and Managing a Full Continuum of Health Services for Manitobans

Health Care – A Component of Health

In Manitoba, when we have spoken of "health care services" we have tended to think of hospitals and physicians. A more balanced view - one that takes all of the determinants of health into account - would see "health services" as being composed of a wide continuum of services from educational and preventive initiatives, through programs of community support, through a range of other possible health services all the way to the high technology environments of modern teaching or tertiary hospitals.

There is no question that a truly effective health services system must have all of these services to enable it to respond to the varying health status needs of our population. But they must be re-balanced to more appropriately meet those needs.

The following chart is a graphic representation of that full continuum of health services.



Restructuring the System to Achieve Effective Patient Care Within the Continuum

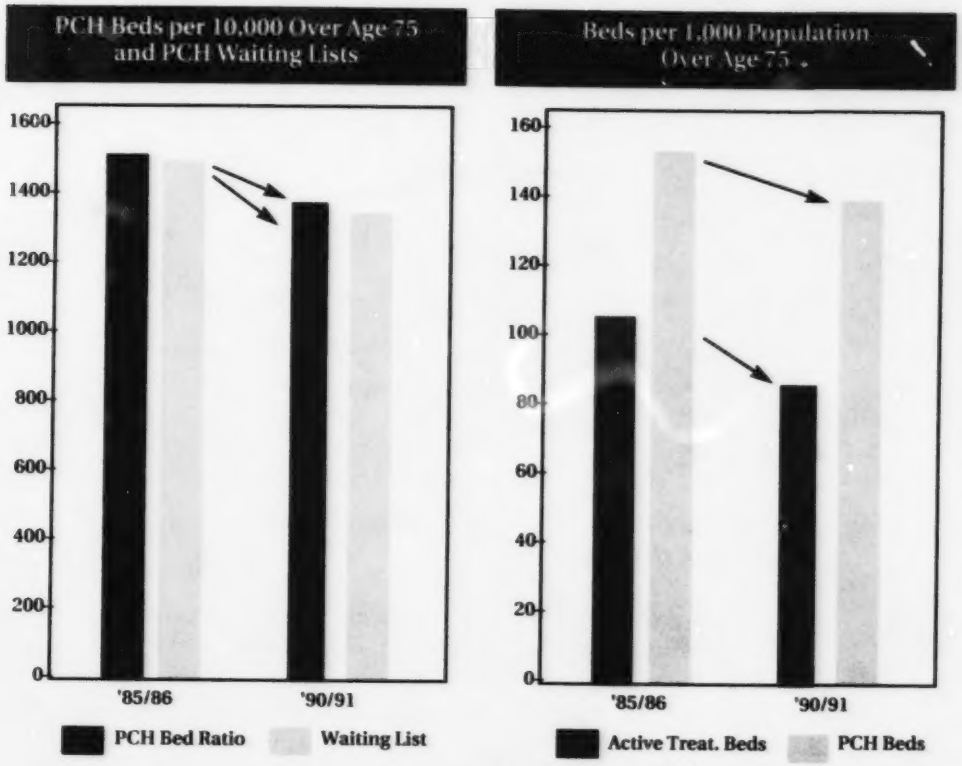
In Manitoba (and the rest of Canada) we need to strengthen the development of the preventive and community-oriented part of that continuum of services.

Alternatives – A Part of the Continuum

For example, too many Manitobans have been placed in mental health institutions who, with appropriate community-oriented services and supports, could have remained in their homes and could have enjoyed far richer lives. We are moving to correct that situation now through Manitoba's **"Building the Future of Mental Health Services in Manitoba - A Continuing Partnership for Reform."** Specific implementation plans are being developed in partnership with the Regional Mental Health Councils. The focus of these plans is to reduce our dependency on hospital beds by putting alternative community-oriented services in place.

Historically many Manitobans - primarily senior citizens - were placed in personal care homes; however, with appropriate community-oriented services and supports they are now able to retain their independence and continue to live in their own homes with their families in their own communities.

With the advent of Home Care in 1974 and Support Services to Seniors in 1984, we have been able to provide alternatives to personal care home services, but even in Manitoba the development of these community services has lagged behind the growth in institutional services.



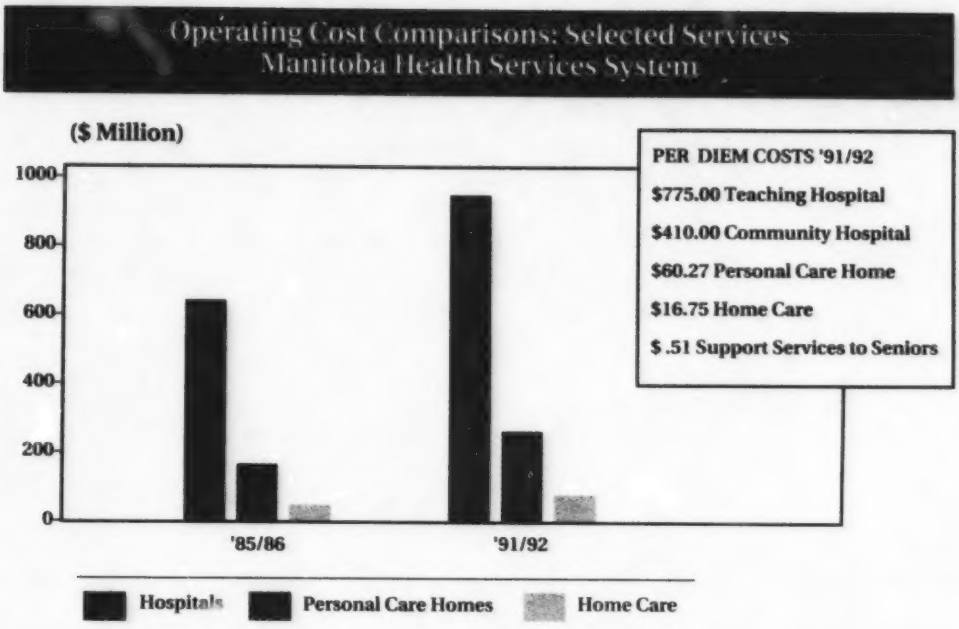
Source: Manitoba Health

Over 75 age group has increased from 4.8% to 5.5% of the population. Both active treatment bed ratios & PCH bed ratios have declined between '85 and '91. PCH waiting lists have also declined indicating the impact of Home Care.

Support Services to Seniors – A Success Story

We're continuing to move to correct this imbalance. Between 1985 and 1991, Manitoba has increased its spending on senior centres and other programs that provide support to the "well-elderly", from $560,000 a year to almost $750,000 a year, to help prevent illness, postpone disability and promote health. At the same time, the province established the Support Services to Seniors Program - a program which provides support to local community projects to meet the needs of the "frail and at-risk" elderly enabling them to remain in their own homes, because congregate meals, household maintenance, yard work and similar volunteer services are available to them. The province increased spending on Support Services to Seniors from $56,000 in 1985 to $1.45 million in 1991. During the same time, the province has increased spending on Home Care - a program that provides essential health care to seniors in their homes, and to others with assessed health care needs - from just under $25 million a year to over $60 million in 1991 and almost $68 million in the 1992/93 fiscal year.

Support Services to Seniors – A Success Story



Note: Support Services to Seniors: $56 Thousand in '85/86, $1.45 Million in '91/92.
Source: Manitoba Health

The above graph shows annual costs and the comparison between the daily costs of some of our main health services. They range from a high of $775 a day at one of Manitoba's teaching hospitals - St. Boniface or the Health Sciences Centre - to less than $500 a day at other acute care hospitals across the province, all the way down to only 51 cents a day for Support Services to Seniors.

Clear Opportunities for Reform

One thing is very clear from this comparison: the cost impacts of inappropriate health services are staggering. The cost of having a person unnecessarily placed in one of our teaching hospitals for a single day could provide several days of care in a personal care home.

Put another way - if, by providing home care services, we can reduce the length of time a person has to stay in an acute care hospital by a single day, we save enough to pay for several weeks of home care. The potential returns from investments in lower cost and community-oriented services are huge and experience elsewhere suggests that these services also contribute to improved health outcomes. To put it simply, that portion of the institutional budget that appropriately covers the cost of providing community-oriented services - moves with the patient.

Aging per se Is Not Cost Driver

A disturbing factor that contributes to unnecessary costs is physician practice patterns. Between 1971 and 1983, the number of Manitobans aged 65 and over increased 31%, however, the total number of physician visits increased 79% and referral visits 272%. Some of this can be explained by the growth in the elderly population, and changes in the level of illness. **However, Manitoba researchers found that a 16% increase in physician visits and 30% increase in referral visits were made by the *well* elderly, who are roughly 90% of the elderly population. Further investigation is required to examine the reasons for increased physician visits by apparently well persons, and to suggest methods to alter this trend.**

To summarize, the third foundation for Manitoba's Action Plan For Quality Health will ensure the following: development of the full continuum of services to shift more of our services from high-cost institutional settings to lower cost and more appropriate prevention, support and home care services to help people avoid illness and delay or reduce their need for institutional care.

The Fourth Foundation: Developing a Government Organization Capable of Managing Change and Improvement in Health Services for Manitobans

Structured for Change

In 1989 Manitoba established the **Health Services Development Fund to support innovation and in particular to support "solutions that contribute to the development of an affordable system and the opportunity to realign existing resources to meet new service requirements".**

As government has sought to engage the health services community as active participants in a cooperative pattern of change through Manitoba's "Partnership for Health", we have also moved to restructure government's own involvement in health service delivery.

The division between community-oriented and institutional health services within the Ministry of Health was removed. The Manitoba Health Services Commission has been transformed from a corporate body primarily responsible for health facilities and insured health benefits to a division within the Ministry with broad responsibilities for integrating the service delivery between community and hospital services.

The Fifth Foundation: Building the Capacity to Systematically Monitor and Evaluate the Quality, Appropriateness, Effectiveness and Outcomes of Manitoba's Health Services

Data Base – Second to None

In Manitoba, we understand that managing health costs is only one part of the challenge that faces us. We must also manage the quality and effectiveness of health services, measured in terms of their contributions to the health status of Manitobans. To do this effectively, all those involved in health services need access to clear information about health outcomes. Manitoba enjoys one very significant advantage as we confront that challenge.

Manitoba has one of the best basic health administrative data bases in Canada (and perhaps in the world). The records in the Health Data Base include more than 18 years of validated and detailed claims data. That information makes it possible for Manitoba to know what health services were provided to all groups in the community and - more importantly - to assist in the evaluation of health outcomes and effectiveness of those services.

Manitoba Centre for Health Policy and Evaluation

***The Manitoba Centre for Health Policy and Evaluation** is funded through the Health Services Development Fund (provincial casino revenues). The Centre comprises university-based researchers who function at arm's length from Government through the Department of Community Health Sciences, University of Manitoba. With two career scientists and associates of the Canadian Institute of Advanced Research, the Centre is instrumental in assisting Manitoba Health in restructuring the system and improving the linkage of health expenditures to outcomes and effectiveness of services. The Advisory Board of the Centre comprises persons of stature with expertise in Provincial, National and International health systems.*

Conclusion: The Basic Management Dilemma: the "cost savings" that are never really saved.

The basic logic we have been describing here - of a shift towards equally effective and lower cost health services - is not news to those who have been involved in health services in Manitoba. It has been a large part of the discussions behind the health policies of successive governments in this province to develop and enhance a range of community-oriented health services.

Common sense would tell us that if we expand our programs of home care so that these services are available to many more people in Manitoba who might otherwise have had to be hospitalized or have had to stay in hospital longer, the incidence of hospitalization and/or the average length of hospital stay should go down and hospital and total health care costs should be contained.

Historically, that has not been the way the health services system has worked in Manitoba or elsewhere in Canada. Instead, each new service that was developed and provided as an **alternative** to high cost medical or institutional care has tended instead to be an **addition** to the existing set of services. Hospital usage and hospital costs did not come down proportionally as alternative services grew - either here in Manitoba or elsewhere in Canada.

Add-ons "Disguised" as Cost Savings

Clearly it was not enough simply to add new services and assume that these resources would result in lower increases in overall system costs. **The real need is to manage all of the elements in the continuum of health services to ensure that they work effectively together to meet the health status needs of the population. That cannot be achieved without a basic restructuring of the health services system to provide appropriate services at the appropriate level by an appropriate mix of service providers.**

SUMMARY

The Foundations for Restructuring the Manitoba Health Services System

- **Develop a broad Government focus on "Healthy Public Policy"**
- **Build a "Partnership for Health" in Manitoba**
- **Build and manage a full continuum of health services in Manitoba**
- **Develop a Government organization capable of managing change and improvement in health services for Manitoba.**
- **Build the capacity to systematically monitor and evaluate the quality, appropriateness, effectiveness and outcomes of Manitoba's health services**

PART THREE:

Quality Health for Manitobans – The Action Plan

Manitoba's Action Plan for Quality Health aims to restructure our health services system to provide appropriate health services for all Manitobans, and to monitor, evaluate, reform and improve all aspects of health services based on their actual health outcomes. **The first and foremost consideration is to improve the health status of Manitobans and to protect the interests of patients and their families.**

Principal Elements of the Plan

The main issues that will be addressed in this plan over the next two years are outlined below:

QUALITY HEALTH FOR MANITOBANS
The Action Plan

- **Develop and strengthen appropriate community-oriented alternative services**
- **Develop a new role for Community Health Centres – broadening the partnership**
- **Restructure the hospital system**
- **Enhance public education/patient empowerment**
- **Implement health human resource plans and resource allocation plans**
- **Reform Systemic Cost Drivers**
- **Implement technology assessment and management**
- **Develop Provincial Health Information Strategy**
- **Evaluate the restructured system.**

The Importance of Asking the Right Questions

Each of these elements will be linked together in an integrated continuum of services from the perspective of needs of individuals. In all cases the same prioritization criteria will apply:

1. **What are the relationships between the health status needs and the services being provided? (Appropriateness)**

2. **Are all services being provided relevant to the health status needs? For example, what are the actual health outcomes of the services being delivered? (Effectiveness)**

3. **Where can the services be most effectively provided in the patient's best interest? (Proximity)**

4. **What is the most appropriate service provider mix (i.e. physician, community service provider, nurse, etc.)? (Matching)**

5. **If there is demonstrable evidence that the service is best delivered through an institution, what level of institution (Selection - institutional):**

   - **Teaching hospital**
   - **Urban hospital**
   - **Community hospital/rural hospital**
   - **Personal care home**
   - **Other**

   .... and, what is the basis of the determination?

6. **If there is no demonstrable evidence that the service must be provided in an institutional setting, where in the community would the service be most appropriately delivered (Selection - Community):**

   - **Outpatient**
   - **Community Health Centre**
   - **Community residential alternative**
   - **Other community sites – services**
   - **Individual's home**
   - **Workplace/school**
   - **Other**

In other words, our approach to restructuring will not simply assume that all of the elements in the health services system are playing the appropriate role now and attempt to make each more efficient. We will examine the role that each plays - from the perspective of needs and outcomes - to ensure that all parts of our integrated system are responding appropriately to the health status needs of Manitobans.

Priority Action:

Community-Oriented Health Services Development Strategy

The Community Strategy

One of the most important causes of Manitoba's reliance on hospital and other institutional health services has been the lack of appropriate alternative services. **Programs such as the Antenatal Home Care Program, a collaborative program between a major teaching hospital and Manitoba Health, currently offered only in Winnipeg, could be available to women province-wide with a minimum of community supports.** This program provides an alternative to women who would otherwise be hospitalized early in their pregnancy. It enables women who are at risk to remain in their home and community until the time of delivery, by providing regular monitoring and teaching in the home by the Public Health Nurse. This program has not only demonstrated a substantial reduction in the use of hospital days but has significantly improved the quality of the pregnancy experience for women and their families. It is estimated that within the first five years of this program operating out of only one institution, $750,000.00 was saved. **Unfortunately, however, because of the lack of a "system" management plan the "savings" were not redirected to provide effective care.**

In Manitoba, our strategy for the development of appropriate alternative services will focus on developing community-oriented services to meet the health service needs of Manitobans. Early discharge programs, currently only offered to low risk post partum families in Winnipeg, which enable women to return home as soon as possible following a birth, could be expanded province-wide, and could also be expanded to include a broader range of patients.

In addition to ensuring that appropriate health service providers are engaged in these community-oriented services, we will also strive for broad community and family involvement. **The Diabetes Education Resource Program is another example of a partnership between the physician, the patient and community – oriented health services.** In concert with the physician, the program provides a standardized educational approach to assist persons with diabetes to achieve and maintain better control of their condition. This program has provided an alternative to hospitalization at the time of initial diagnosis.

The progress already made in Manitoba's reform of mental health services is indicative of the potential for this approach. Working in conjunction with Regional Mental Health Councils we are developing a range of services - including both ongoing services and crisis support teams - that will make it possible for hundreds of Manitobans who, in the past would have been institutionalized, to live successfully in their communities among their families and friends.

Similarly, our rapidly growing programs of community Support Services to Seniors - by providing relatively basic services earlier than health services have been provided in the past - are making a significant contribution to the

continued health and independence of thousands of senior citizens across Manitoba. **At the same time, by increasing the capacity of the Home Care Program to provide more intensive care than in the past, many seniors who would have been institutionalized - perhaps permanently - are now able to stay in their own homes and communities.**

In our vision of Manitoba's health services system, appropriate health services are defined as those services **"that can be delivered closest to the person's home, involving the least possible intervention or loss of independence for the individual, and that can be provided at the lowest total financial and social cost, consistent with the health and daily needs of the individuals involved".**

Effective community-oriented services contribute directly to personal health and independence for the individual and, by avoiding, delaying or reducing the individual's need for higher cost institutional services, they also contribute to a more affordable total health services system. We will ensure that these services undergo rigorous evaluation to ascertain that they meet those objectives.

Bridge Funding Will Facilitate the Provision of Community-Oriented Services before In-Service Patient Reductions are Achieved.

Manitoba Health will provide bridge funding during fiscal years 1992/93 - 1993/94 in those instances where innovative community-oriented alternative services are introduced (e.g., Home Care Services) until such time as commensurate in-hospital services are curtailed and hospital budgets are redirected to meet community service needs.

Appropriate funding adjustments will be made to hospital budgets to reflect the following provincial requirements:

The Need to Manage Separate Cost Centres to Become More Effective and Efficient

- **A separate cost accounting is established by the hospital reflecting approved community per diem costs;**
- **Program standards of eligibility are determined by and adhere to provincial program standards;**
- **An alternative funding method for particular disease entities would be separately identified from the overall hospital global funding.**
- **The staffing mix and classification levels would be consistent with similar community-oriented staffing resources.**

Innovative Pilots – Good for the Patients but at Lower Costs

Short Term Emergency Program Pilot Projects

Manitoba hospitals will be encouraged to participate in pilot projects which are designed to:

- provide people who come to Emergency Departments with an opportunity to receive care at home rather than being hospitalized;
- provide people who appear in Emergency from other institutions with an opportunity to be returned to the institution of origin and receive care; and
- develop appropriate screening tools to determine what is required for social triage in an Emergency Department.

The pilots will be evaluated to:

- determine the impact and effectiveness of expanding the service delivery hours in the community, e.g., 16 hour availability of assessment, case coordination and mobilization of services to provide care in the home;

Evaluation – A Necessary Requirement

- determine the actual cost of services that are delivered in Emergency Departments separate from costs required to support people who are sent home from Emergency still in need of care that would otherwise have resulted in hospitalization;
- demonstrate cost comparison and quality control of services purchased or provided through non-governmental entities;
- demonstrate health education. Teaching individuals who use the emergency system, e.g., professional staff, as well as community groups and individual families, what are appropriate services to which Emergency Departments can respond.

A Rational Approach

Manitoba will continue to provide the necessary funding to ensure that home care and other community oriented services - including community oriented personal care home services - are available to meet the needs of Manitobans. In all cases, the determination of what is an appropriate level of service will be based on the specific health status of the individual, and the health outcomes - for individuals, specific groups and the community as a whole - will be carefully monitored and evaluated. The results of that monitoring and evaluation will serve as a guide to further improvement and reform of these services and to the development of clearer guidelines or protocols for the selection of appropriate services for individual Manitobans.

Reform of Emergency Departments

Physician Involvement

To improve efficiency of emergency departments, Manitoba Health will seek the expertise of, and a collaborative arrangement with, the Heads of Winnipeg's Emergency Departments to develop a comprehensive reform of Emergency Departments. Emergency Physicians have suggested a number of system changes which could improve patient care and at the same time, promote efficiency and cost savings. The initiatives range from alternatives to remuneration, staffing, preventing the need to attend an emergency unit, admission policies and many others. Similar arrangements with other physician groups will occur.

Priority Action:

Broadening the Partnership... with Community Health Centres

As the need for a more comprehensive array of community-oriented services will be required to support the restructuring initiative, Manitoba Health will be seeking to enhance the working partnership with community health centres.

The Role of the Community Health Centres

This working relationship will seek to bring about the following:

- improve coordination of primary care services, e.g., the relationship of primary care services provided at a tertiary care centre that may be more effectively delivered through a community health centre setting with the appropriate community-oriented cost centre and program standards.
- encouraging participation in the development of innovative community-oriented pilot projects specially targeted to "at risk" populations likely to use institutional-oriented services, particularly tertiary care centres.
- to assist in the development and delivery of healthy lifestyle promotion programs to further bring about the systemic shift to health promotion and prevention.

The result of this working relationship will be a greater involvement and active participation of the local members of the community. This will serve to reinforce one of the fundamental principles of Healthy Public Policy whereby citizens assume a greater responsibility for their own health status.

Priority Action:

Hospital System Reform

Manitoba's Action Plan for Quality Health has four key goals for the reform of the hospital system. They are:

Hospital Reform Goals

- **to ensure that Manitoba has an appropriate number and mix of various kinds of hospital beds and that each part of the hospital system plays an appropriate role in the delivery of health services to Manitobans**
- **to provide funding to hospitals in a manner that will promote, assist and encourage the provision of appropriate services and enhanced quality of services**
- **to improve the quality of health services provided by Manitoba hospitals evaluated in terms of their health outcomes.**

- **to provide hospital boards and institutions with an opportunity to re-focus as *"Centres of Excellence"* with an emphasis on services rather than on beds.**

How many and what kind of hospital beds do we need?

There is general agreement that - in comparison to international standards - Canada has more hospital beds in total than are necessary to meet the needs of our population.

In addition, a disproportionate share of total beds are in the teaching or tertiary hospital sector - the highest cost part of the health care system. The relatively high cost and rapid rate of increase in cost of hospital services is a major contributor to the affordability crisis that is facing Medicare in Canada.

In Manitoba, hospital resources - and the highest technology hospital resources in particular - are relatively heavily concentrated in Winnipeg. Residents of rural or northern Manitoba make significant use of these urban resources not simply in cases where that is appropriate but because, in many instances, there are no alternative services in the form of rural or northern institutional or community-oriented service.

General Hospital Bed Comparisons
Canada & Manitoba
1989/90

	Canada	Manitoba
No. of Beds: All General Hospitals	178542	6459
Beds/1000	6.79	5.95
Per Capita Operating Costs: All General Hospitals	$761.47	$769.03
No. of Teaching Beds	40602	1914
Teaching Beds/1000	1.55	1.76
Per Capita Operating Costs: Teaching Hospitals	$270.76	$369.27

Note: A study to be released shortly will add perspective to the issue of teaching hospital costs.

Source:Statistics Canada, 1989-90 data

In part, this over dependence on hospital care reflects the evolution of health services in Manitoba and Canada, with its concentration on these highest cost forms of service. Our heavy reliance on hospital-based services has also reflected the relative under-development of other aspects of the health services system in Manitoba and a lack of knowledge about existing alternatives among patients and service providers.

Hospital Utilization

One of the greatest sources of pressure on hospital facilities and hospital costs arises from the fact that there may be far too many people in hospital who could be more effectively cared for in an alternative setting. Research done in other jurisdictions, such as by the B.C. Royal Commission on Health Care, indicates that at least 25% of admissions to hospital are either not necessary or would have been unnecessary if alternative services were available. Manitoba data shows that many of the patients admitted to the Winnipeg hospitals from rural Manitoba, including those coming to the highest cost teaching centres, do not require complex care. Many of these patients might have been appropriately served by other facilities or services if these were available. Although the teaching hospitals are our most expensive, most high-tech institutions, they appear to admit many patients with uncomplicated disease who may well be better served at community hospitals.

Complexity of Rural Cases Coming to Winnipeg (1990/91)

DRG Weight	St. Boniface	Health Sciences Centre	Other Winnipeg Hospitals
percentile			
91-100 (most complex)	11%	11%	6%
81-90	7	8	7
51-80	15	18	23
21-50	25	29	27
11-20	6	7	14
1-10 (least complex)	36	27	23
Number	4466	7042	5465

Note: DRG: Diagnostic Related Group
Source: Manitoba Centre for Health Policy & Evaluation

Distribution of Cases at Winnipeg Hospitals (1990/91)

	St. Boniface	Health Sciences Centre	Other Winnipeg Hospitals
Pneumonia & Pleurisy			
No Complications	47%	45%	40%
Moderate	39	41	43
Major Complications	14	13	17
Total	262	484	643

Source: Manitoba Centre for Health Policy & Evaluation

Towards an appropriate mix of hospital and alternative health services

Other jurisdictions that achieve comparable or better overall health status with less reliance on hospitals devote a larger percentage of their total health spending to the provision of lower cost but equally effective services.

Our goal is to reallocate resources within the hospital sector and between the hospital sector and other elements of the health services system to achieve a more appropriate and cost-effective range of health services.

The approach we have adopted to address the question of numbers and kinds of hospital beds, has been to engage the hospitals themselves in identifying services they are now providing that could more appropriately be provided in a lower cost hospital, an alternative institution or in the community.

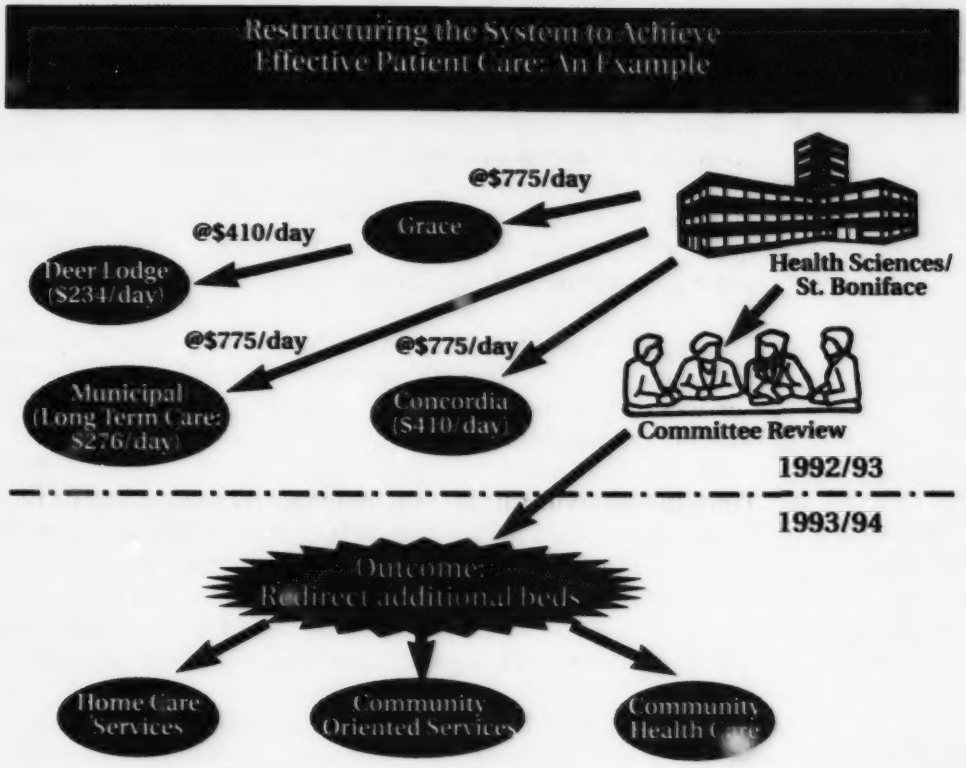
The Approach: Effectiveness and Appropriateness

Once these services have been identified, resources will be moved - from teaching hospitals to community hospitals or long term care facilities, and from institutions to the community-oriented services where that is appropriate. In the process, each hospital and each kind of hospital will define its role more clearly and this will lead to improved quality of services and to a reduction in duplication and inefficiencies in the system.

Where it can be substantiated that alternative services are required, there can be no reduction in hospital or other institutional health services in Manitoba until and unless appropriate alternative services have been identified and made available. But where there are lower cost and equally effective ways of providing services, resources will be reallocated to ensure that those alternatives are provided.

A strategic shift of resources to provide an appropriate mix of hospital and other services - measured by patient need and health outcomes

Manitoba has developed a phased, two-year plan to shift resources through the cost/technology spectrum from teaching hospitals, through urban and community hospitals to long term care facilities to home care and other community services. The aim is a coordinated reduction in the inappropriate pressure on higher cost forms of health service through the expansion of equally effective, more appropriate and lower cost services.



The Strategic "Shift" Effective and at Lower Cost

The process will be driven by a clear definition of the role of various kinds of hospitals in Manitoba and the relationships between them to ensure that all Manitobans have access to appropriate services, including access to the services of teaching hospitals.

In all cases, appropriate alternative services will be in place prior to (or at the same time as) the shift of resources. The groundwork for this restructuring has already been laid and bridge financing from the Health Services Development Fund will make it possible to retain services while alternatives are being developed.

The 1992-93 and 1993-94 Implementation Plan

First – The Opening of Beds

In keeping with the theme of effectiveness and the continuum of care, Manitoba will transfer resources in 1992/93 from the highest-cost part of the health services system - our two teaching hospitals - to more effective forms and levels of health services in Winnipeg by:

- **further increasing the Home Care budget**
- **opening 40 personal care beds at Deer Lodge**
- **adding 50 additional beds in the Municipal Hospital**
- **opening 60 beds at Concordia hospital.**

Initial Impact

Commensurate with the increase of resources for Home Care and other necessary support services and with the opening of a combination of 150 beds at Deer Lodge, Municipal Hospital and Concordia Hospital, 240 beds will be closed at the Health Sciences Centre and St. Boniface Hospital. **This will result in 90 fewer beds in the system as a whole but will see an increase in alternative services.** This shift from hospital to community oriented services will be achieved with the aid of "bridge" funding where appropriate.

The resulting mix of home care, personal care, long term care and acute care beds will provide more appropriate health services. In addition, the introduction of the Short Term Emergency Program pilots is expected to reduce pressure for hospital bed services.

Second – The Creation of Community Support

During 1992/93, as part of Phase II of Mental Health Reform, we will also begin replacing acute care psychiatric beds with an array of community mental health supports including crisis management services to help persons with mental illness to manage and function effectively in the community.

...Patient Concerns and Protection

The replacement of acute care psychiatric beds will not occur until an array of community-oriented services are in place. The development and implementation of this range of services will involve consumers, community groups and the full range of community health supports. Patient services (outpatient and day treatment) will generally continue at their present location in order to ensure that patients' concerns remain top priority. However, this will not preclude consideration of requests for placing these services in other locations as long as patient needs can be met.

Developing a Medical and Scientific Basis for More Effective and Quality Patient Care - A Unique Model to Protect Manitoban Patients.

The initial reallocation of resources from teaching hospitals to more effective forms of institutional or community care will involve the transfer of patients who, in the opinion of the clinical staffs of the various institutions affected, have already been identified as "inappropriately" or unnecessarily placed in the system and who can more appropriately and cost-effectively be provided with alternative services.

The total scope of this initial shift of resources, however, will not significantly alter the balance in the system away from our current over reliance on hospital services - and high technology hospital services in particular - and towards a more balanced and appropriate full continuum of services.

Additional transfer of resources from and within the hospital sector, however, cannot be undertaken except with the most careful possible medical monitoring and evaluation to ensure that health service needs continue to be met and that health outcomes are carefully evaluated.

What Does Research and the Literature Say?

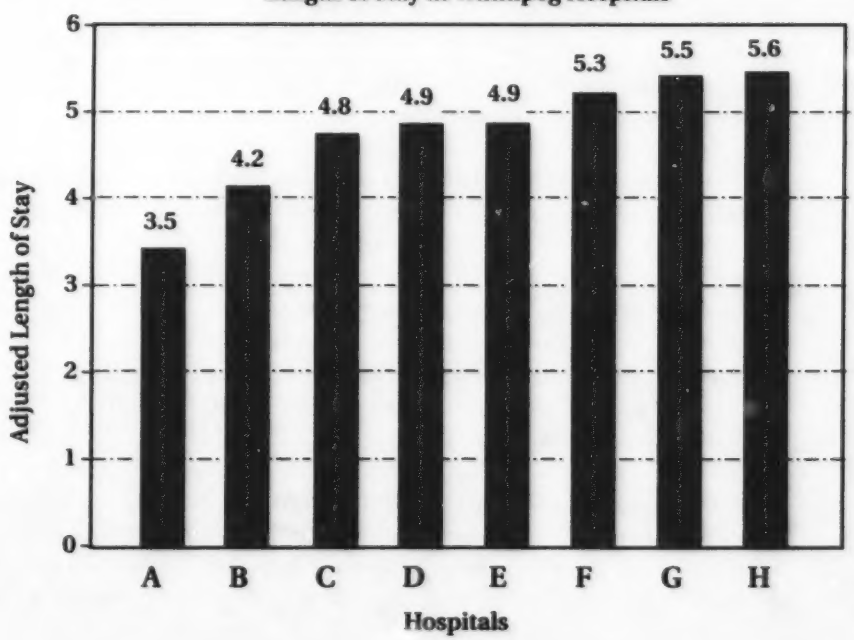
"The amount of medical care people receive varies substantially, depending on the local hospital market area, and the region or the country where they live ... "Admission rates for more than 80% of medical conditions ... are highly variable. For these, the need for hospitalization is less clearly defined and physicians differ from area to area on when hospitalization is appropriate". (John Wennberg, M.D., New England Journal of Medicine, January 30, 1986).

"Manitoba has longer average lengths of hospital stays than other jurisdictions for similar treatments and its re-admission rate following selected surgical treatments may be cause for concern. Costs will, however, only be saved by shortening lengths of stay or reducing the number of re-admissions if an equivalent number of acute care beds are closed". ("Manitoba Health Care Studies and Their Policy Implications", April 1991 - Manitoba Centre for Health Policy and Evaluation).

Opportunities for optimising the "balancing" of our health services are clearly evidenced by some of the examples depicted below:

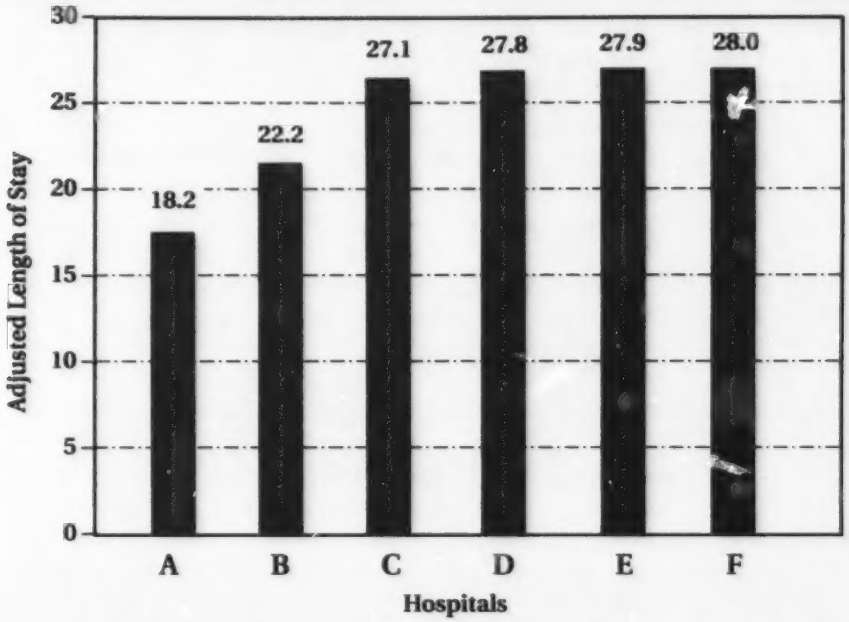
Opportunities for Change ....for Continuous Quality Improvement Techniques

ESOPHAGITIS, GASTROENTERITIS, AND MISCELLANEOUS DIGESTIVE DISORDERS



Source: Manitoba Centre for Health Policy & Evaluation, 1990-91 data

PSYCHOSES
Adjusted Length of Stay in Winnipeg Hospitals



Source: Manitoba Centre for Health Policy & Evaluation, 1990-91 data

On a temporary basis, resources and patients will be redirected from approximately 200 hospital beds in Winnipeg and Brandon effective March 31, 1993, as more appropriate alternative services are developed and put in place.

At least six months prior to the March 1993 temporary bed closures, an evaluation protocol will be implemented through the joint expertise of Dartmouth-Hitchcock Medical Center for the Evaluative Clinical Sciences; Department of Community Health Sciences, University of Manitoba; and the Manitoba Centre for Health Policy and Evaluation.

Science, Research and Evaluation for Patient Protection

This evaluation will have a number of components. One will rely upon the administrative databases of the Ministry of Health and will carefully monitor the impact of the bed closures. Another will monitor the health status and physical functioning of selected representative samples of the population before and after the planned bed closures.

Manitoba Health will not only be concerned about patients' medical condition - but will assess the social and gerontological impact of bed closures.

The Ministry will negotiate with the Manitoba Centre on Aging to participate in the evaluation process to ensure that the social functioning of patients receiving services outside of the hospital setting is consistent with appropriate and effective health status standards.

The results of the scientific evaluation will help to determine the number of beds to be closed permanently by Manitoba Health ... and will assist in the planning and evaluation of community health and home-based services.

A Scientific Basis for Managing Waiting Lists and Priorities in the Hospital Sector

Although Manitoba has - by international standards - relatively more teaching hospital beds and, in particular, relatively more high cost, high technology beds in relation to our population than other jurisdictions, the pressures on our hospital system arising from inappropriate hospital admissions or lengths of stay have resulted in constant "waiting lists" for a variety of procedures. The evidence would suggest that hospitals and physicians in Manitoba are largely successful in ensuring that services are provided when needed, but delays in access to services are still a concern.

There is also a need for clear medical and scientific guidelines and protocols that hospitals and physicians can follow in making appropriate decisions relating to urgent referrals and scheduling within the health care system which will allow for those most in need to be taken care of on a priority basis.

To meet that need, Manitoba has established the Appropriate Access Review Group. This study group includes the Medical Vice Presidents of Manitoba's two teaching hospitals, the Executive Director of the Manitoba Cancer Treatment and Research Foundation, the Medical Vice President of the Victoria General Hospital - all leading Manitoba physicians - and the Executive Director of the Evaluation and Audit Secretariat of Manitoba Health.

The group's work will be assisted by Dr. C. David Naylor, the Director of the Institute for Clinical Evaluative Sciences at Sunnybrook Health Science Centre in Toronto, together with representatives of the Manitoba Centre for Health Policy and Evaluation, the Department of Community Health Sciences from the Faculty of Medicine at the University of Manitoba.

The group's mandate is to develop better mechanisms for managing urgent referrals scheduling in the Manitoba health care system focussing, in particular, on Orthopedic Surgery, Cardiovascular Surgery, Angioplasty, Oncology and Cataract Surgery.

Within six months, this group will have reported and recommended protocols based on:

- **protection of patient health status**
- **consistency**
- **appropriateness**
- **equitable access.**

There is, in objective terms, no real shortage of hospital services in Manitoba. By developing and applying these province wide protocols, we can ensure that our resources are used in an appropriate and consistent manner across the health services system of Manitoba.

Cardiac Care — A Special Need for Provincial Review

Monitoring a High Risk Program

Open Heart Surgery *Waiting List*

	August 1990	June 1991	April 1992
Health Sciences Centre	66	28	37
St. Boniface General Hospital	165*	167	130
	231	195	167

(* approximate number)

Manitoba recognizes the need for ongoing review in the area of heart health and cardiac care and will seek improved efficiencies and improved effectiveness in cardiac care.

Providing Leadership

Currently there is a urgent need for defined leadership in cardiac surgery and cardiology. Manitoba Health will work cooperatively with the two tertiary care hospitals and the Medical School to ensure expeditious recruitment to fill these vital leadership positions in this most critical area.

Manitoba Health will ensure that appropriate coordination and rationalization of our **Cardiac Care Provincial Program** is effectively in place in the best interest of Manitobans.

Appropriateness of Hospital Care

A Necessary Requirement to Substantiate Further Redirection of Hospital Resources

An external consultant, Dr. Geoff Anderson, from the University of British Columbia will be engaged to work with the Winnipeg/Brandon Inter-Hospital Medical Staff Council to review the appropriateness of hospital care.

Hospital care is appropriate if the patient requires services that are best provided in the acute care in-patient setting. Inappropriate use of hospital resources can result from either the admission of patients who do not require hospital resources or the failure to discharge patients after they have received required services. Currently, tools have been developed that can identify inappropriate hospital use. The Winnipeg/Brandon Inter-Hospital Medical Staff Council has agreed to undertake a systematic assessment of the appropriateness of hospital utilization. This study will measure the levels of

inappropriate hospital utilization and will determine the extent to which it is due to:

1) **lack of appropriate community or family resources;**
2) **delays in providing services within hospital; and**
3) **physician practice style.**

This study is targeted for completion by March 1993. The results of this study should provide information required for improving the use of acute care hospitals and coordinating hospital and community-oriented services. **Based on its results, the closure of up to an additional 75 beds across the hospital system may be implemented in fiscal year 1993/94. Appropriate alternative services will be provided as required. This review will be dynamic, taking into account all current system changes that occur concurrent to the appropriateness review.**

An Opportunity and a Challenge for Manitoba Health Professionals

Challenges–Choices–Challeges–Decisions–

The restructuring of Manitoba's hospital system poses a challenge to all those concerned with patient welfare and population health. Because change is difficult, Manitoba Health fully expects a vigorous discussion of the planned restructuring of the hospital system. Because of their professional knowledge and personal experience, moreover, Manitoba's physicians and nurses can make an important contribution not only to this discussion, but also to the reform itself by carefully articulating their professions' concerns for patients, and through helping to identify potential solutions.

Physicians' and nurses' participation in the design and implementation of the evaluation protocol will thus be explicitly encouraged and, to the extent feasible, the evaluation of the hospital system restructuring will be designed to take account of their concerns. The challenge to physicians and nurses is therefore:

The Partnership Challenge

- **Recognize that change is inevitable – the current system clearly over-invests in institutional oriented care;**
- **Recognize that the reform of the hospital system can reflect physicians' and nurses' concerns only if they participate in the process; and**
- **Join the evaluation process – to ensure that their special knowledge of their patients' interests are incorporated into the design of the evaluation.**

The Security of a Quick Response and Avoidance of "False Alarms"

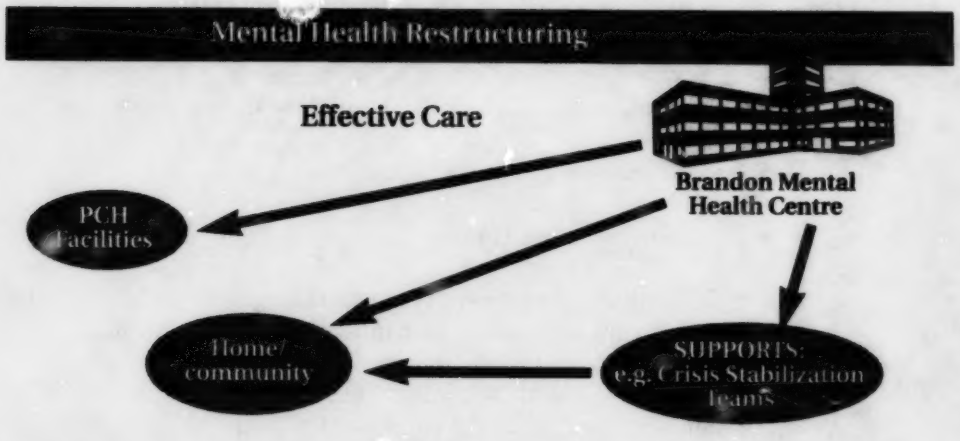
The Manitoba Centre for Health Policy and Evaluation working with scientific consultants, with active participation by Manitoba health professionals, will thus monitor and provide ongoing feedback to the Ministry on the impact of the hospital system restructuring. This model process of "government - researcher - health professional" cooperation provides a sound basis for a "phased and monitored transfer of resources" to redirect both funds and patients to more appropriate levels of care within the province. The model process will also ensure that the reallocation of resources reflects appropriate responses to meet the needs of Manitobans while minimizing any possible adverse effects on health outcomes.

The model will provide the medical scientific basis for a "phased and monitored transfer of resources" to redirect the resources from approximately 200 hospital beds in Winnipeg and Brandon hospitals as more appropriate alternative services are developed over the next two years.

Completing the Mental Health Reform to provide "appropriate" care for each patient

In addition to those acute care psychiatric beds that will be closed in Winnipeg, we will also continue Manitoba's Mental Health Reform by redirecting the resources from up to 250 beds at the Brandon Mental Health Centre to more appropriate forms of community-oriented health service.

The Interaction of the Mental Health Reform Strategy



A careful patient evaluation has shown that the majority of the people in the Brandon Mental Health Centre could be in more appropriate settings. A large proportion are elderly and are receiving no significant or ongoing treatment that could not be equally well provided - closer to their homes and at lower cost - in personal care facilities or other supportive housing. Another significant group has the capacity to live and function in the community if appropriate housing, vocational and crisis response services are made available.

The goal is to provide effective health services for the individual.

In the case of other hospitals with designated psychiatric units, including our highest-cost, highest technology teaching hospitals, a proportion of the people being treated there may be better served in other settings. Alternative services may not only be at lower cost, but may also be better in social terms, making it possible for people to be more independent and to remain closer to their homes and their families and - often - to remain in their homes and with their families.

The development of the alternatives - of a full continuum of health services with careful monitoring of health outcomes in concert with the medical profession - will also free the highest cost, highest technology parts of the health services system to play the role they ought to play - that of providing services that only they are capable of providing.

The 1992-93 and 1993-94 Implementation Plan - restructuring in rural Manitoba

Rural Health Advisory Council

The newly established **Rural Health Advisory Council**, chaired by the Deputy Minister of Health, *will be challenged to implement, by fiscal year 1993/94, a realignment of up to 200 rural hospital beds that could be more effectively used by such examples as:*

- **placement of mental health patients in accordance with the principles of mental health reform;**
- **redirected services from urban centres;**
- **replacement of some acute care beds with long term care facilities;**
- **home care services and supports;**
- **community health centres;**
- **reviewing the progress of Westman Integrated Strategy for Health (W.I.S.H.) to determine regional applicability where appropriate.**

We will apply the same model process to achieve a "phased and monitored transfer of resources" in the rural areas of Manitoba. Once again, where it can be substantiated that alternative services are required, any redirection of resources will be undertaken only where appropriate alternative services are available and all health outcomes will be carefully and scientifically monitored by the medical profession of Manitoba.

We will also continue monitoring the outcomes of the major changes made during the 1992/93 - 1993/94 Implementation Plan to ensure that health outcomes are in line with our goal of achieving health services that are not only better in terms of the health of the people of Manitoba, but also more affordable.

Hospital System Reform – Systemic Changes

Ensuring that Manitoba has an appropriate number and mix of hospital beds can mean better and more affordable health services

Canadian experience nationwide over the past two decades has proven that putting ever-increasing amounts of money into the system is not the answer.

Instead we have learned that continual expansion of the highest cost forms of health care merely perpetuates the problem of excessive health costs and makes no measurable difference in the actual health of our population. This fundamental restructuring of health services - by redirecting resources towards more appropriate health services including services specifically designed for prevention and to ensure that people stay healthy enough to avoid the need for institutional care - can meet our goal of a health services system that is both better and more affordable.

How can we fund hospitals to support and encourage quality and cost effectiveness?

Funding Linked to Effectiveness

The traditional funding method for Canadian hospitals is "global budgeting" - an approach that sets a total amount that the hospital will spend each year. Generally speaking, cost control in global budgeting is achieved by putting a "cap" or ceiling on the money available to the institution for the year. Management decisions and the allocation of resources within the hospital are left largely to the hospital administration. This approach does not provide the hospital system with effective "signals" as to the kinds of services it ought to provide; it treats hospitals as isolated institutions rather than as part of an integrated health services system.

The Manitoba Centre for Health Policy and Evaluation has completed a study of alternative approaches to hospital funding. The study points out that the advantage of the global budgeting approach from the hospitals' perspective is that it is familiar and it results in relative financial stability and management autonomy. From a government standpoint, the global budget has offered a very direct way of managing expenditures. The main weakness of this approach is that it does not link hospital spending to any systematic evaluation of effectiveness of the services being provided or the effectiveness of care as measured by health outcomes.

In part, this weakness will be addressed through the cooperative efforts of the hospitals to define their roles and the effectiveness of their services relating to the number and kind of hospital beds required to meet our needs in Manitoba.

Building a stronger quality and cost-effectiveness focus into hospital funding

The Centre's study also recommended that additional measurement tools and management approaches be developed and employed along with the global budgeting approach to focus more clearly on quality and effectiveness concerns.

Among the approaches that are being developed for use in the managment of Manitoba hospitals as part of the larger health care system is what is called the "policy envelope" approach. In this approach, resources are allocated to a broad health care area such as cancer or cardiovascular care. This approach provides a policy focus for systematic efforts to evaluate and improve the appropriateness, efficacy and cost-effectiveness of hospital services in each "policy envelope" as they relate to the broader spectrum of services.

Neoplasms (1989/90)

Age	% of Patients	% of Services	
0-19	7.1	3.8	
20-44	28.7	16.9	
45-64	27.0	27.7	
65-69	9.6	12.0	
70-79	17.1	25.4	39.8%
80+	10.0	14.4	

Source: Manitoba Health

CIRCULATORY SYSTEM (1989/90)

Age	% of Patients	% of Services	
0-4	1.6	0.5	
20-24	16,3	9.0	
45-54	31.8	26.7	
65-69	12.7	13.2	
70-79	23.1	27.4	50.6%
80+	14.7	23.2	

Source: Manitoba Health

The forgoing charts show the comparison between the percentage of medical services and costs for such treatments in different age groups. On a per person

basis the age group over 70 years old received more services than any other age group within the diagnostic category.

The Need for Public Information and Debate

More importantly, the data also signal the need for an aggressive approach to promotion and prevention programs focusing on the age group between the ages 45 - 69, in order to eventually reduce the high volume of individuals needing high cost interventions in the later years.

We do not now have good data on the health outcomes of these interventions, but there is a serious question as to whether or not this very aggressive pattern of treatment contributes to quality of life or improved health for those being treated. **The answers to these concerns need to evolve through reasoned debate based on research, scientific evidence and Manitoba's social response to this complex issue.**

For example, Manitoba has contributed funds to the Manitoba Cancer Treatment and Research Foundation as part of a major World Health Organization Collaborative Study on Quality of Life in Cancer Care. The data from the study will assist the dialogue.

Variations in Treatment Patterns

There are variations in patterns of treatment among hospitals that do not appear to be directly related to variations in the health conditions of the people they are treating. These variations have implications both for the health of the patients involved and for total health care costs.

The Need for More Continuous Quality Improvement

Example: Obstetrics
Variations in "C" Sections 1990/91

	No. of Deliveries	"C" Sections	% of Deliveries
Hospital "A" Physician Group	1,141	210	18%
Hospital "B" Physician Group	4,378	814	18%
Hospital "C" Physician Group	4,122	694	17%
Hospital "D" Physician Group	889	109	12%
Hospital "E" Physician Group	1,423	148	10%
Hospital "F" Physician Group	1,576	153	9%

Source: Manitoba Health

Are "C" Section rates appropriate?
Are variations across institutions appropriate?

For example, this chart shows the incidence of Caesarean Sections among women giving birth in six different Manitoba hospitals. Why is the percentage so much higher in some hospitals than in others? By focussing on these kinds of differences and by engaging the leadership of the medical profession in developing better guidelines and criteria for such interventions, a more managed approach can ensure better quality of care.

Average Length of Stay for Selected Surgery ('90/91)
(No. of Days)

Hospital	Tonsilectomy/ Adenect.	Appendectomy	Hernia	Dislocations, etc.	Joint Repair
Hospital "A" Physician Group	1.2	5.3	5.8	39.7	34.0
Hospital "B" Physician Group	1.4	4.6	4.5	21.6	19.1
Hospital "C" Physician Group	1.9	6.3	8.8	13.0	21.1
Province	1.9	5.3	6.2	20.9	22.2

Source: Manitoba Health

This chart compares the average length of stay in hospital for some common surgeries among a number of hospitals. Why are there such variations? Are the longer stays really justified in health terms? Focussing on these kinds of differences and engaging the leadership of the medical profession in developing better guidelines and criteria for such things as length of stay can have significant impacts on health costs.

By adding the "policy envelope" system of management to the basic global budgeting approach to hospital funding we can retain the advantages of the familiar system while enhancing our ability to manage both quality of care and health costs in relation to health outcomes.

Total Quality Management or Continuous Quality Improvement

"Total Quality Management is a broadly based organizational approach for continuously improving clinical practices and service delivery performance at every level of the organization by meeting or exceeding patient expectations and desired health status outcomes ...".

"The key features of a Total Quality Management system include:

- **a continuous improvement philosophy;**
- **a focus on patient/consumer/client needs and expectations;**
- **senior management commitment;**
- **employee participation at all levels;**
- **the use of statistical methods to solve problems".**

(Utilization Management - Canadian Council on Health Facilities Accreditation, February 1992).

The Commitments to Continuous Quality Improvement

In the Throne Speech of December 5, 1991, the Government of Manitoba indicated a commitment to introduce Total Quality Management into the Health Care System. In addition, a further commitment was made for the establishment of a Health Status Improvement Fund in part to provide one-time funding to support the health care system in the introduction of quality services that would improve quality to patients/consumers/clients of health services.

A Steering Committee reporting to the Deputy Minister has been established to introduce a system wide provincial health strategy. A Provincial Symposium on Continuous Quality Improvement (TQM) is planned for the Fall of 1992 and will include a wide range of partners including the private sector.

The Continuous Quality Improvement Strategy

The Ministry will encourage the Steering Committee to focus on coordinating TQM action in the following areas:

- Outcome indicators development
- Clinical guidelines
- Technology Assessment
- Special Demonstration Project
- TQM Skill Training
- Quality/effectiveness information systems
- Reduction of the policy barriers to TQM.

Funding "Quality" And Cost Effective Alternatives

The first project to be funded under the Health Status Improvement Fund is Victoria General Hospital's "birthing facility" - Labour, Delivery, Recovery, Post-Partum Program (LDRP) designed to maximize women's control and independence and their choices of an appropriate, efficient and cost-effective environment.

This should encourage an increasing proportion of health services required for healthy and normal childbirth being housed in a community hospital rather than a tertiary hospital and in specifically "low interaction" parts of these hospitals.

Hospitals as an integral part of Manitoba's integrated health services system - focussing on quality

The fundamental direction of our hospital funding reform is to ensure that Manitoba hospitals have the financial resources they need to play an appropriate role in Manitoba's full continuum of health services. The development and application of rigorous scientific and medical monitoring

and evaluation will ensure that Manitoba's Action Plan for Quality Health also promotes and encourages each hospital's efforts to play a more appropriate role within the health services system and to play that role more effectively in terms of both costs and health outcomes.

By clarifying roles, reallocating resources where that is appropriate and by adding an ongoing focus on evaluation and improvement in services to our basic hospital funding approach, we can provide both better and more affordable health services to Manitobans.

Priority Action:

Public Education/Patient Empowerment Strategy

The Public as a force for improvement in health services

Two dramatic and creative reforms in modern health services in Manitoba have been primarily driven not by health services professionals but by the "consumers" of health services.

Pregnancy and childbirth are states of health

The Importance of Public Imput

The approach to pregnancy and childbirth within health services has evolved perhaps more rapidly than any other aspect of health services. Women have insisted that **pregnancy is a state of health, and childbirth is a normal process.** Women want to give birth safely, with control and dignity. Interventions that were "routine" face increasingly critical public appraisal. Women's influence is transforming this aspect of Manitoba's health services.

A "less intervention" approach to pregnancy and childbirth also has implications for the roles of various health services. Increasingly, we will see our highest-cost high technology tertiary hospitals providing services to women who are "at risk" with the vast majority of normal births taking place in community hospitals. Hospitals and public health programs are joining forces to provide the best support to new and growing families once women leave the hospital after childbirth. These shifts clearly meet the definition of appropriate health services in our vision of Manitoba's future health services system.

The Impact of Public Imput

There can be no question that, as a result of the demands of women themselves, our health services system now provides better and, for the most part, lower cost services to mothers and babies throughout Manitoba. There is very little question that this evolution will continue to be driven primarily by the choices of the public.

The culmination of this evolution to date will see increased interest and development of LDRP programs, i.e.,

- Labour, Delivery, Recovery, Post-Partum Program
  - single room maternity care from admission to discharge
  - private room equipped to handle all low-risk births.

This latest evolution in Canadian maternal care provides first for mother and child and is more cost effective than conventional, multi-transfer maternity care.

Most people with mental illness could remain in the community

Mental health services in Manitoba are in the midst of a fundamental process of reform. Increasingly, institutional services are being replaced by community-oriented services that provide the supports to make it possible for those with mental illness to continue to live in their own homes or communities.

Manitoba is not the first jurisdiction to pursue a strategy of moving from institutional to community-oriented services. During the 1960s to 1970s, there was a North American movement to vastly reduce institutional mental health services. In far too many cases, the results were tragic because the institutional service was removed without providing for community-oriented services that could help ensure that patients were able to make and sustain an adjustment to community life. They only did half of the job.

In Manitoba, we will not be repeating that mistake. Largely through the efforts and leadership of mental health advocates including current and former patients and their families and care-givers - we are developing the necessary spectrum of resources (crisis services, supportive housing options, psycho-social rehabiiitation) to provide services as close to home as possible and with reduced dependency on institutional services.

Once again - the energy that drove these reforms came not from the health services system or from health professionals but from the demands of the recipients of these health services. The result will be better and more appropriate health services and reduced costs.

Empowering Manitobans - alternatives, information and choice

Manitoba believes that the informed choices and decisions of individuals can be a powerful force that will lead to better and more affordable health services. But for informed choice to be effective, it is essential that:

- **there be realistic alternatives**
- **the individual has information about the existence and implications of those alternatives**
- **the individual has the right to choose.**

Providing realistic alternatives

Alternatives

Our strategy of developing a full continuum of health services aims to provide individuals with alternative forms of service. The existence of Support Services for Seniors provides an alternative to seeking medical or other health care. Home care programs provide alternatives to entering an institution.

We are optimistic that, as the leadership of Manitoba's medical profession develops more clear guidelines and practice patterns, there will be fewer procedures that are accepted as "routine" and greater scope for patient choice.

Providing information to support informed choices

Alternatives - whether they be alternative forms of health service delivery or alternative treatment strategies - have little value to the individual if he or she in unaware of them or if the information required to evaluate them is lacking.

In partnership with the health community, Manitoba Health will work to ensure that Manitobans are aware of health service alternatives. We will rely on all of the members of Manitoba's Partnership for Health - especially the medical and nursing professions - to help ensure that this information is available and that it is communicated clearly.

Foundation for Informed Medical Decision Making

In addition, Manitoba will work to provide patients and their families with effective information about the nature and value of various medical interventions. Research has suggested that some of the variations in treatment patterns are due to the lack of adequate information for patients about the risks and benefits of alterntive treatments. For example, Dr. John Wennberg, of the Centre for the Evaluative Clinical Sciences at Dartmouth-Hitchcock Medical Center, showed that when information about prostate surgery is made available to patients through an interactive video program they were better able to share in the decision-making with their physicians. The adoption of this "Shared Medical Decision-making" model in various sites in the U.S. led to significant decreases in the rates of prostate surgery. Of particular importance, both physicians and their patients were enthusiastic about the information.

Of significance is the fact that the research indicated that the men who chose to avoid surgery had no serious medical problems within six months to a year after their decision.

Manitoba will provide similar information resources on a variety of subjects, some of which will be developed here under the guidance of leading Manitoba physicians and based on Manitoba analysis of the health outcomes of various alternatives. Under consideration is the development of interactive videos for prostatectomy, cardiac surgery (including information on cholesterol screening and hypertension) and mammography.

People need information in order to be able to control their own lives. ***Ensuring that patients and their families have clear and accurate information about available health services and about the nature of common medical interventions is a key part of Manitoba's strategy to empower consumers.***

The right to choose more effective services

The reforms in health services related to pregnancy and childbirth that women in Manitoba have achieved have made our health services both better and more affordable. The key element in that success story has been the insistence of women that they - and not the health system - have the right to choose services that are more effective.

We will continue to work to ensure that, within health services in Manitoba, individuals have access to alternatives, that they are provided with the information they need to understand those alternatives and that their right to choose among the available alternatives is acknowledged and respected.

Breast cancer screening: an example of "empowerment"

The Power of Public Information

Each year in Manitoba more than 600 women get breast cancer. It is the second most common form of cancer in women in Canada (after skin cancer) and is the leading cause of cancer-related deaths among women.

Early diagnosis is key to the effective treatment of breast cancer. Currently, there are three methods of screening for the disease: breast self-examination (in which women check manually for lumps or irregularities that could be early symptoms), mammography (basically a "breast x-ray") and professional breast examination (examination by a trained health care provider).

Because of the relatively high incidence of this disease and earlier optimism about early diagnosis in its treatment, there has been some pressure for global use of mammography - either on all women or on all women aged more than 50 (the highest risk group).

Manitoba has carefully reviewed the suggestion that mammography be made universal for all women or for all women over fifty years of age. Our analysis of health findings worldwide is that the "jury is still out" on the value of this procedure.

There appears to be no evidence that widespread mammography leads to improved outcome of breast cancer nor that it contributes to improved health outcomes for individuals who are affected. There is also significant uncertainty as to the longer term health impacts that frequent exposure to x-rays may have on otherwise healthy women who are subjected to this procedure.

As a result - after some three years of study and examination involving the leading medical experts in Manitoba and reviewing studies done worldwide - Manitoba has decided against a "universal" mammography program, at this time.

The Policy Approach

Our policy, instead, can be summarized as follows:

- **We will continue to work closely with the medical profession to encourage all women to use breast self-examination to detect irregularities or other possible early symptoms of breast cancer**

- **Manitoba Health will sponsor the development and dissemination of an educational program on breast cancer, including a video tape to provide women and their physicians with the most current medical analysis of the risks and value of mammography and other screening techniques**

- **Diagnostic mammographic examinations will continue to be available to all women who, for reasons of family history or perceived breast irregularities, feel themselves to be at risk of this disease**

- **Manitoba Health will establish an ongoing Advisory Group of leading health experts to monitor advances in breast cancer screening to ensure that practice here reflects the highest possible standards worldwide.**

We believe the individual woman must have information about all of the alternatives and about the implications of each.

In summary, the leadership of all health care providers - in helping to ensure that alternatives exist, in helping to ensure that information about all alternatives is available and is communicated clearly to individuals and their families, and in assisting individual Manitobans in reaching appropriate decisions - will be essential. We are confident that a systematic effort to empower individuals can help ensure that they become an increasingly powerful force for improvement in health services and in the health of Manitobans.

Priority Action:

Physician Human Resource Plan and Allocation

The protection of the Health Service Providers

There are thousands of people who earn their living as "service providers" within Manitoba's health services system. The restructuring of the system will affect them and their careers and options in a significant way.

For some - including a wide range of therapists - the result will be a need for more of the skills they have to offer. For other employees in health services, the shift away from our over concentration on "bed-based" services may require new skills and a new orientation.

The service providing professions that have played the most dominant role in health services - physicians and nurses - will face different and evolving roles and opportunities in the health services system of the future in Manitoba.

The men and women who have been employed in Manitoba's health services system have always performed to a standard that is among the highest in the industrialized world. As resources are redirected across the spectrum to more appropriate health services, there will be employment impacts that will affect some of these men and women.

Their Significant Contribution to the System

As part of its strategy for restructuring health services, Manitoba will attempt, to the extent possible, to consider re-location assistance, provide re-training and assistance in finding new employment - within health services, elsewhere in government or in the economy at large - for any person so affected. We will encourage these men and women to seize the new opportunities that will result - for a broader range of career options for nurses in community-oriented services, for different patterns of practice and for rural or northern practices for physicians, nurses and other health care providers.

The individuals who actually provide health services to Manitobans deserve a great deal of the credit for all that is best about health services in Manitoba and we will provide every reasonable assistance to ensure that they can continue to thrive and to contribute to Manitoba in the future. A committee will be established to coordinate **The Health Services Provider Commitment Plan** ***- a plan to reduce the extent of negative impact for employees as a result of the restructured system.***

Physician Resource Policy Development -

As a result of reveiwing the Barer/Stoddart Report, the Provincial/Territorial Conference of Ministers of Health agreed to the following national policy directions at the January 28, 1992 Ministers' Conference:

1) To reduce by the Fall of 1993 Canadian medical school entry class size by 10%. Future adjustments will reflect progress on other physician resource initiatives.

2) To reduce national postgraduate medical training positions by 10%.

3) To reduce the recruitment of visa trainee graduates of foreign medical schools into Canada for postgraduate medical training.

4) To support the development and implementation of national clinical guidelines with an emphasis on health outcome research, that can serve as a basis for the funding and provision of both ambulatory and institutional medical services.

Physicians Key Players in Restructuring

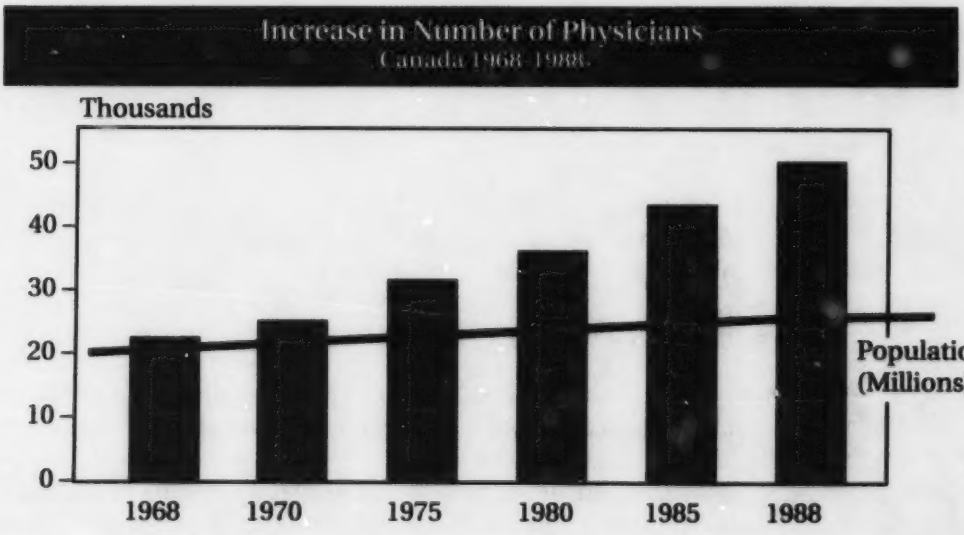
Physicians in Manitoba and across Canada have been among the leaders in our shared efforts to provide a range of appropriate health services to meet the needs of our people. Physicians themselves are also a very significant element in total health costs, directly through the fees they are paid under Medicare and indirectly through their control of access to hospital and other health service resources. **Any serious effort to achieve better and more affordable health services must also involve the medical profession.**

Manitoba's Action Plan for Quality Health has three key goals for its interaction with the medical profession in Manitoba. They are:

- **to ensure that Manitoba has an appropriate number and mix of physicians to efficiently meet the needs of people in all parts of the province**
- **to provide compensation to physicians in a manner that is fair and that reflects the health service needs of Manitobans and the value of the services in terms of cost and effect on patient care.**
- **to support the leadership of the medical profession in its efforts to continually enhance the quality and the health outcomes of medical practice throughout Manitoba.**

How many physicians do we need?

The number of physicians in Manitoba and across Canada has been growing far more quickly than our total population. The Health Ministers of Canada have identified this growth as a significant contributor to rapid increases in total health costs.

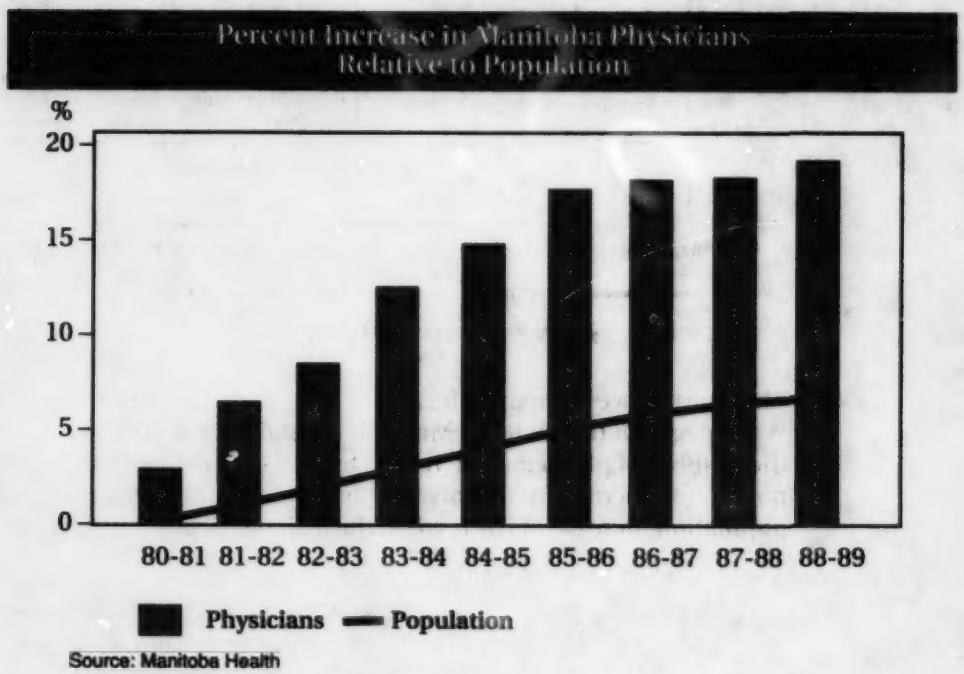


Source: Statistics Canada

Physician Growth

As the previous chart shows, between 1968 and 1988, the number of physicians in Canada increased at about twice the rate of population growth for the same period.

That nationwide trend - with growth in total numbers of physicians outpacing population growth - has been even more pronounced in Manitoba over the past ten years.

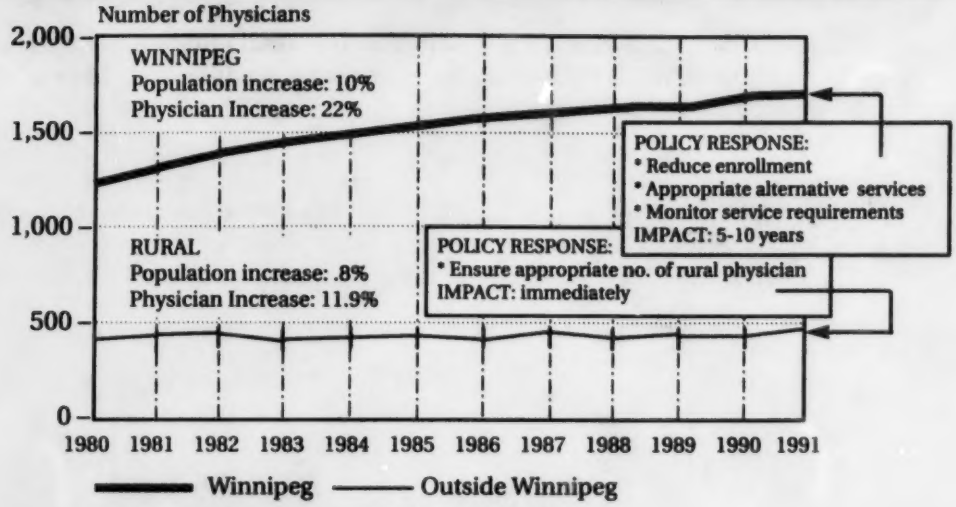


As this chart shows, during the decade of the 1980s alone, the number of physicians in Manitoba increased by almost 20% while our population grew by only about 6%.

Where do we need the Doctors to be located?

We have had long-standing shortages of physicians in rural and Northern parts of Manitoba. The profession and government have worked together to try to ensure adequate medical services in all parts of the province. These efforts have had some success.

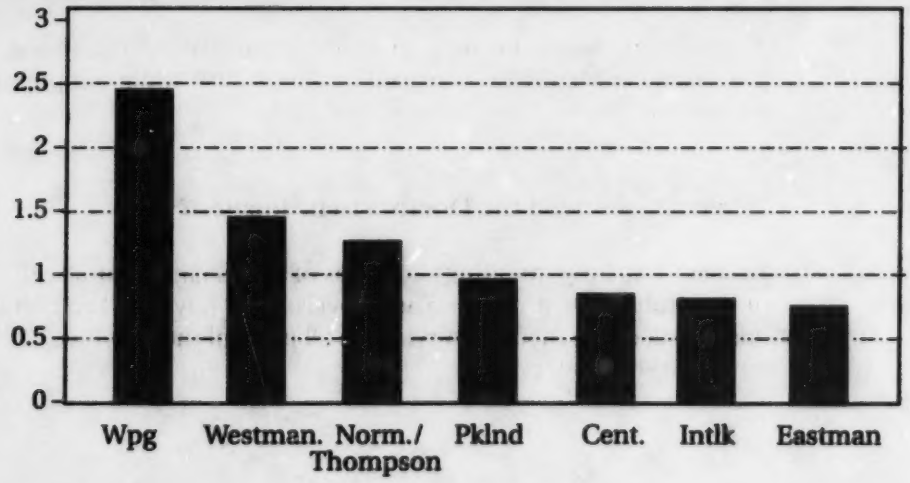
Growth of Physicians in Winnipeg and the Rest of Manitoba (1980-1991)



Source: College of Physicians and Surgeons of Manitoba Data

The chart above compares the rate of increase in the number of physicians in Winnipeg with that in Rural Manitoba over the 1980-1992 period. In Winnipeg, the number of physicians increased by 22% over this period - compared to a population increase in the city of only 10%. In rural areas, there was a marginal population increase of 0.8%, while the number of physicians increased by 12%.

Physicians per 1000 Population by Health Region 1990



Source: Manitoba Health

The chart above shows the number of physicians per 1,000 people in each of Manitoba's eight Health Regions. In Winnipeg, there are about two and one-half physicians for each 1,000 people; in Eastman, there is less than one physician for each 1,000 people.

From time to time, Manitoba has faced severe shortages of particular medical specialties. The concentration of physicians in Winnipeg is even more pronounced among specialists in short supply. For example, of the total of 122 psychiatrists registered in Manitoba only 12 practice primarily outside of Winnipeg. There will need to continue to be specific and targeted efforts to address such shortages of necessary medical care.

A strategy for appropriate numbers and location of physicians - a challenge to physicians and to medical education in Manitoba

The Strategy for Change

Manitoba, in concert with the other provinces of Canada, has developed a strategy to manage the total number of physicians. Our provincial strategy also includes measures to ensure that there is an appropriate number of physicians to meet the needs of all parts of the province.

The thrust to the overall strategy is to slow the growth in total numbers of physicians. To that end, we are holding discussions with the Faculty of Medicine, University of Manitoba regarding reductions in the medical school's first year entry class size, and the number of post-graduate medical education positions.

At the same time that we will be working to slow the growth in total numbers of physicians, we will be working closely with the profession to ensure adequate medical services in rural areas. This represents a challenge - both to the profession and to medical training in Manitoba.

We will continue to use the Standing Committee on Medical Manpower to implement a variety of incentives to encourage doctors to set up practices outside of Winnipeg. Where necessary we will continue to recruit foreign trained physicians to meet medical needs in rural areas. But the reality is that, if we are to provide appropriate health services to the people of Manitoba, more physicians and a more balanced mix of physicians must choose to "go where the need is" - to rural and northern Manitoba.

Government will do its part to ensure that appropriate facilities exist to support rural practice and that the financial rewards are commensurate with the value of the contribution physicians can make to these parts of the province, but we also look for leadership from the profession in meeting that challenge.

Medical training - to answer Manitoba's need for physicians

Manitoba's medical school must not forget that it is training physicians to meet the needs of Manitoba. This implies that our medical school should train people in specialties and sub-specialties that are relevant to Manitoba's real

need for medical services. It also implies that our medical school should increase the number of students they accept from rural and northern areas where the need for physicians is greatest (people from northern and rural areas are more likely to return to such areas once they graduate).

We will also be requesting the medical school to review its training to ensure that it is appropriate for physicians who will be practicing in rural areas or outside the teaching hospital environment. Increased clinical training could actually take place in community or rural hospitals to help ensure that graduates are competent and confident to practice in these environments. The value of clinical training in Thompson, for example, both to the physicians being trained and to the hospital there, would be significant - and a significant number of northern Manitobans may be less inclined to come to Winnipeg tertiary centres for treatment and fewer referrals would be required. All Manitobans could benefit.

Proliferation of Specialists and Sub-Specialists - A Challenge to the Medical School.

There are currently approximately 48 different specialist and sub-specialist programs within Manitoba's medical school; some programs may include one person. The school will be required to rationalize the need for this comprehensive mix and its direct relationship to the current and projected health status needs of Manitobans. Given its population base, Manitoba's 48 programs far exceed Saskatchewan's 25 programs.

Manitoba Health encourages the further development of the Western Canadian Consortium on Health Care to pursue the concept of Centres of Excellence and inter-provincial rationalization of medical programs. These efforts will be part of an over-all national strategy.

A Real Need - Physician (Clinical) Scholars

Medical Training – Looking to the Future

Manitoba's Medical School will be encouraged to train physicians in such areas as outcome research and how to effectively utilize Manitoba's administrative data base. In order to ensure the efficacy of a large number of medical practices and procedures more emphasis needs to be placed on researching the outcome - the real effect - of these medical practices. The ability to utilize our data base would also substantively improve the knowledge of physicians of both outcome and potential risks of physician practices. Manitoba's Medical School has a unique opportunity for leadership in Canada. Tradeoffs in this area with some sub-specialty training have the potential to provide patients with improved opportunities for more quality medical practices - a "win-win" for physician and patient. **Manitoba Health will be considering a significant initiative to introduce this concept.**

At the same time, the Ministry is committed to protecting stability of funding

for phyician education and for the world-leading biomedical and health services research base which we have in this province.

Managing Medical Costs

Medical Cost – An Anecdotal History

"Governments have a long history of regulating medical practice. In 2200 B.C., Hummurabi, King of Babylon, brought in laws that limited doctors' fees ....".

"In Europe in the 14th Century, most parts of the Holy Roman Empire had laws about medical training, the licensing of doctors and physicians' fees".

(The Economist, July 6, 1991)

Most physicians in Manitoba and across Canada are paid on a "fee-for-service" basis. In general, fee negotiations between governments and the medical profession have tended to focus on the total percentage increases in the overall fee schedule with the profession being primarily responsible for deciding how any increases are to be allocated among the fees for the various procedures physicians may provide.

There are disparities between the Physicians' Manual (i.e., physicians' fee schedule) and those of other provinces. In addition, there are variations in income potential for physicians within different areas of practice. The profession in Manitoba has agreed to conduct a joint examination with Government, of the Manitoba Fee Schedule, to bring about a more equitable distribution within the total funds allocated.

The Urgent Need for Fee Schedule Reform

Medical Fee Schedule Disparities

Procedure	Per Day
Endoscopy/gastroscopy	$4,627
rheumatologists	540
sessional rates	390
	Per Procedure
cardiac surgery*	
– Manitoba	$2,339
– Ontario	1,260
colectomy*	840

*** Note: 3 graft by-pass & colectomy each take 2-3 hours**

Source: MHSC Data & Ontario Data

As the forgoing chart shows, a specialist in Endoscopy can earn $4,627 per day under the current fee schedule. By contrast a Rheumatologist (a specialty in short supply can earn $540.00 a day).

The Manitoba Medical Association has the responsibility for the allocation between various groups within the profession. Historically, the medical profession has guarded its control of the Fee Schedule.

Manitoba Health encourages the urgency for reform and will continue to work with the profession to identify and address disparities or anomalies in the Fee Schedule and their effects on the range of medical services available to Manitobans. The government will also work with the profession to ensure that physicians' compensation includes recognition of desirable changes in patterns of practice. For example, in areas like prostate surgery, where it appears desirable for physicians to devote more time to informing potential patients of the implications and options involved in this once "routine" procedure, there would be compensation for the time and effort involved in lieu of potential surgery activity that patients may choose not to have.

Fee for service is an approach that is highly valued within the profession but government will also be encouraging the implementation of various other forms of payment, e.g., block funding for medical services. Implementation of alternative forms will be introduced in cooperation with the profession to ensure that there is no change in the doctor/patient relationship.

Priority Action:

Systemic Cost-Driver Reforms

Diagnostic Laboratory Services - Alternatives for Operational Efficiency

Diagnostic laboratory services in Manitoba are provided by the following sectors:

- **major urban hospitals;**
- **private fee-for-service laboratories which serve Winnipeg and Brandon;**
- **provincial operated Lab and X-ray Unit Services which serve rural Manitoba;**
- **Westman Regional Laboratory;**
- **Cadham Provincial Laboratory;**
- **private physician offices; and**
- **the Red Cross**

Diagnostic Laboratory Services – The Need for Reform

Overall, the cost of diagnostic laboratory services in Manitoba has increased at 7.6% annually in the Province between 1982/83 and 1987/88. This is slightly less than the rate of growth in overall health care costs, which have increased at 7.7% over the same period. However, over the period 1982/83 to 1987/88, a breakdown of the laboratory component of diagnostic costs shows that the private fee-for-service laboratory costs of diagnostic services has grown at an annual rate of 9.7% vs. 6.6% for all publicly funded laboratories. Currently, the cost of private fee-for-service diagnostic laboratory services has the second highest cost growth index of all monies paid to physicians for health care services.

Total payments to private laboratories approximated $27.5 million in 1990/91. Most of the growth in laboratory testing expenditures is related to an increase in the number of tests ordered and performed (rather than the actual fee increase).

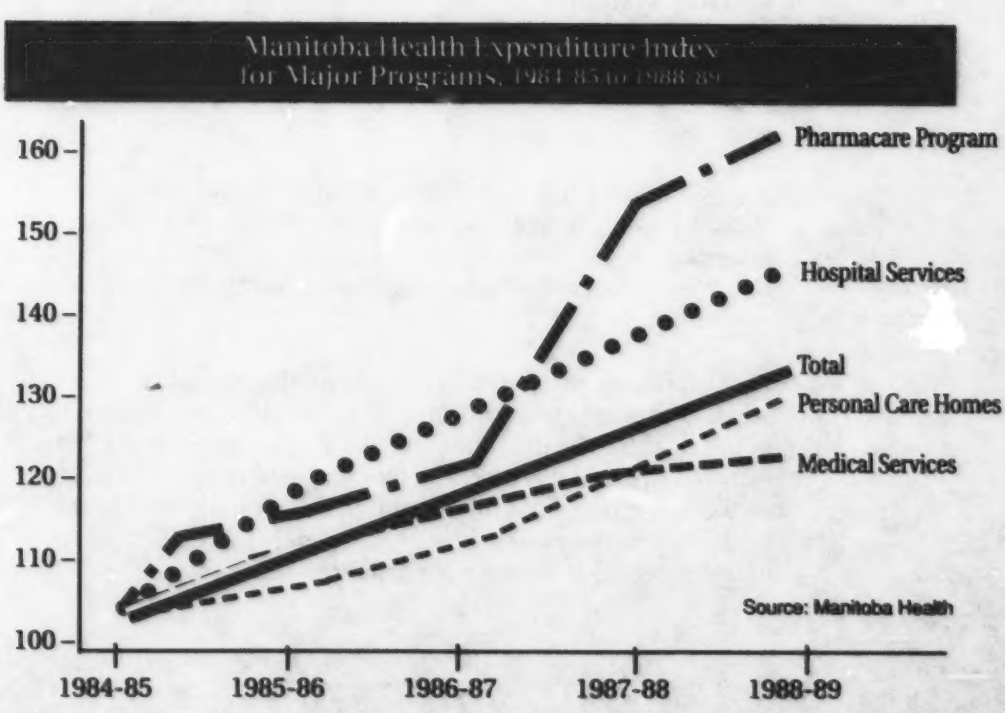
A current study by the Urban Hospital Council is examining the issue of utilization of lab testing, including the elimination of duplication of testing prior to hospital admission. Included as well, should be the development of protocols in consultation with the College of Physicians and Surgeons in order to ensure the appropriate tests are ordered.

Manitoba Health will be expediting a public policy approach that would look at a range of alternatives to bring about improved efficiencies including:

1. Tendering diagnostic laboratory services for personal care homes in Winnipeg;
2. Reviewing the potential for conflict of interest;
3. Developing rigorous protocols in concert with the College of Physicians and Surgeons;
4. Examining all laboratory fees for both private labs and private physician offices in consultation with the Manitoba Medical Association; and
5. Encouraging Continuous Quality Improvement techniques to be an integral part of the management of laboratory services.

The Policy Option

Manitoba Pharmacare Program – A Cost Crisis



A Cost Crisis and A Plan for Action

It is evident from the foregoing graph that Manitoba Health must, on an urgent basis, implement a series of policy decisions to affect a range of pharmaceutical issues.

Currently Manitoba Health is represented on a Federal/Provincial/ Territorial subcommittee which is preparing a comprehensive report addressing, **"Cost Effectiveness, Drug Benefits, Drug Pricing Controls, Interchangeability and Therapeutic Guidelines"**. The reports and recommendations are to be presented to the Federal/Provincial/Territorial Deputy Ministers of Health in the Fall of 1992.

A Drugs Benefit/Cost Investigator will be appointed immediately to coordinate and provide a provincial perspective to the Federal/Provincial/Territorial reports and will include the following:

1. **The management of the program from a single responsibility centre within the Ministry;**

2. **The consistent, rational and equitable application of cost containment/benefits strategies.**

The Investigator will report no later than October, 1992.

Engaging leadership within the Medical Profession

The goal: physicians as full participants in an integrated health services system

Physicians are key players in any effort to improve health services and health outcomes in Manitoba and in our strategy to develop more affordable health services.

Partnership with the Medical Profession

The role of the physician within health services has been likened to that of a "Gate Keeper". It is physicians who must decide who shall be admitted to hospital, what treatment they will receive while they are there, what tests will be run, what drugs will be dispensed and how long the patient will spend in the institution.

Physicians can also play a key role in guiding people to alternative health services that may be more appropriate or in influencing behaviour to foster better health. The decisions that doctors make act as the "trigger" for most health costs, and it is essential that physicians be informed of all alternative services that may be available and that the profession provide effective leadership in the establishment of standards or guidelines to assist individual practitioners in reaching appropriate conclusions.

The College of Physicians and Surgeons - A Leadership Role

The College of Physicians and Surgeons is being asked to provide leadership in the ongoing review of the various health care areas involved in the implementation of **"Manitoba Health Care Studies and Their Implications"**. The goal will be to establish clear guidelines and patterns of practice that, in the opinion of the leading physicians in Manitoba, should be adhered to. We will look to the college to provide leadership in this ongoing reform, making use of the information available from the Manitoba Health Data Base and other monitoring to enhance the quality of medical care provided to all Manitobans.

The profession in Manitoba is responding to this challenge and Manitoba Health aims to support medical leadership as a key agent for improvements in quality of care and containment of health costs.

The Medical Profession – A Partnership

The fundamental obligation of Manitoba Health - and of the physicians of Manitoba - is to contribute to the health of Manitobans. The Medical Profession in our province and across Canada is a "self-governing" profession and our physicians take that status and its attendant responsibilities very seriously indeed. They will find, in Manitoba Health, a willing partner in their efforts to make that self-governance a stronger, more effective force for exemplary medical practice and enhanced health outcomes for all Manitobans. In particular, Manitoba Health will continue to work cooperatively with the profession in the development of the scientific yardsticks that are necessary - to evaluate and manage resource reallocation within the health services system, to evaluate and establish standards for patterns of practice and guidelines and protocols for appropriate decision-making.

Priority Action:

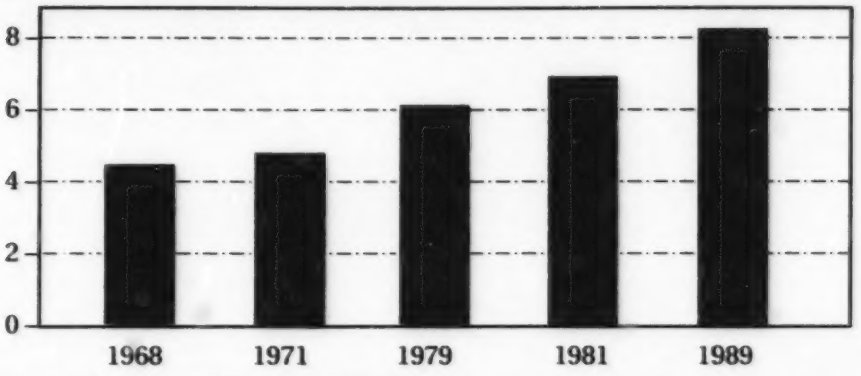
Nursing resource policy development

Provincial Nursing Advisor

The nursing professions - including Baccalaureate Nurses, Registered Nurses, Licensed Practical Nurses and Registered Psychiatric Nurses - play a key role in both institutional and community-oriented health services in Manitoba.

A Key Role for Nurses

Manitoba Nurses Per 1000 Population



(Registered and employed in Nursing) Source: Health and Welfare Canada

An Issue for Open Discussion

Paid Hours, Nursing Department, per Patient-Day in Reporting Hospitals, by Type of Hospital, 1988-89

	Ont,	Man.	Sask.	Alta.	B.C.	Canada
Public General: Non-teaching with no long term units	7.21	7.87	6.02	7.25	7.62	7.51
Non-teaching with long term units	6.49	7.59	5.23	5.86	5.76	6.51
Non-teaching total	6.66	7.73	5.77	6.37	5.90	6.77
Teaching (excl. pediatric)	9.11	11.01	8.10	9.45	7.78	8.71
All Public General	7.31	6.85	6.76	7.84	6.21	7.37
All Public Specialty	10.51	6.09	-	12.67	16.09	10.80
Public - Total	7.09	8.62	6.64	6.97	6.10	6.85

INDEX: CANADA = 100.0

	Ont,	Man.	Sask.	Alta.	B.C.	Canada
Public General: Non-teaching with no long term units	96.0	104.6	80.2	96.5	101.5	100.0
Non-teaching with long term units	99.7	118.8	80.3	90.0	88.5	100.0
Non-teaching total	98.4	114.2	85.2	94.1	87.1	100.0
Teaching (excl. pediatric)	104.6	126.4	93.0	106.5	89.3	100.0
All Public General	99.2	120.1	91.7	106.4	84.3	100.0
All Public Specialty	97.3	56.4	0.0	117.3	149.0	100.0
Public - Total	103.5	125.8	96.9	101.8	89.1	100.0

Note: Specialty hospitals includes Pediatric, Psychiatric and other hospitals.
Source: Table 8, Cat. 82-0038 Quarterly, Canadian Centre for Health Information, Hospital Statisitics: Preliminary Annual report 1988-89

The number of registered and employed nurses in Manitoba has been growing faster than our population over the past two decades. This reflects the rapid increase in hospital spending and medical activity. It also reflects a gradual broadening of the scope of practice open to nurses as more community-oriented services and preventative programs are developed. However, more importantly it shows that within Manitoba hospitals, **paid hours per patient-day may be the highest in Canada.**

Government has been working with the nursing professions and others in the health services system to develop a stable, long term strategy for nursing education to ensure that we have appropriate numbers of nurses with appropriate skills and training available to meet the needs of our evolving health services system.

Registered Psychiatric Nurses are the mainstay of community mental health services, especially in rural and northern Manitoba. Traditionally, RPNs have been educated in separate programs at the two Mental Health Centres in Brandon and Selkirk. These two programs have been consolidated into one new educational centre for Registered Psychiatric Nurses based in Brandon. As a result, educational and career opportunities for RPNs will be enhanced with the planned movement of the program to a university setting.

The Health Ministry needs the support of RPNs educated in the new enhanced diploma program, and the proposed baccalaureate program, especially in light of the shortage of psychiatrists and other professional resources in rural and northern Manitoba.

There is a very significant uncertainty in any effort to forecast nursing requirements arising out of proposed changes in the "nursing mix" - the combination of Baccalaureate Nurses and Licensed Practical Nurses - that are being considered in major care institutions. *There is an additional set of uncertainties, e.g. 1) the role and extent of part-timers; 2)the impact of system changes; 3) the wide range of new career opportunities; 4) new requirements for the special skills that nurses can provide. In light of these uncertainties, it is impossible to make long term decisions about training strategy and appropriate numbers at this time.*

Developing a five year nursing resource plan

A Plan to Provide Focus

Manitoba Health has asked the health care institutions to provide information on their current nursing staff and their five year projections of requirements for nurses including specific information on the mix of BNs, RNs, LPNs and RPNs they believe will be required.

In addition to providing base line data, this nursing resource survey will provide us with information that can be used in developing longer term training strategies. The forecasts will be monitored against real trends as these emerge to ensure that our education strategies continue to be responsive to Manitoba's evolving needs.

An important perspective in making health services better and more affordable

Nursing Professions – Key Partnership

The nursing perspective - on the operations of hospitals and other institutions and on the needs for the potential of community-oriented services - is an important perspective in Manitoba's overall effort to develop better and more affordable health services.

The government will continue to work to ensure that the nursing professions and their unique perspective play an active and creative role - as full partners - within Manitoba's Partnership for Health.

An integral part of the development of Manitoba's nursing resource policy development will be the appointment of a **Provincial Nursing Advisor** reporting to the Deputy Minister of Health.

One of the principle responsibilities of this position will be to provide leadership in the development of policies and implementation of strategies respecting a comprehensive range of nursing policy issues.

Priority Action:

Technology assessment and management

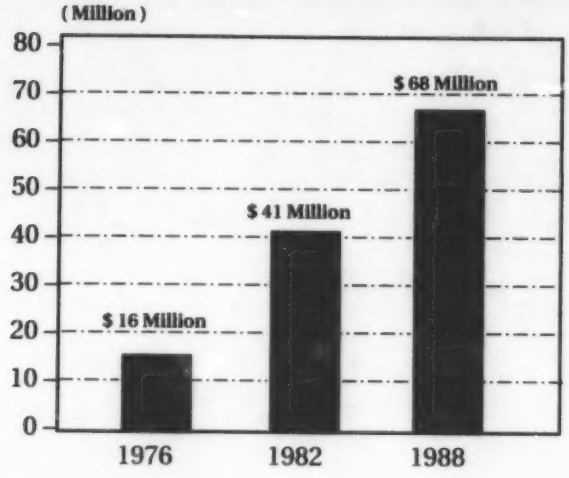
Technology – A Cost Driver

Medical technology - and diagnostic technology in particular - has achieved amazing advances in recent years. The promise of emerging technologies has led to huge and rapid investment especially but not exclusively in the hospital sector. But while Manitoba hospitals - and others throughout Canada and internationally - have invested in technology, a number of serious management issues that affect both the quality and the affordability of health services have not been adequately addressed.

CT Scanners and Imaging Technology: a case in point

There have been few more dramatic advances in technology than the advent of CT Scanners and, more recently, even more advanced Medical Imaging Technology. But the costs and the benefits of operating this technology as it is being used in Manitoba are problematic.

Manitoba Health Care System
Total Cost of Medical Imaging



Notes:

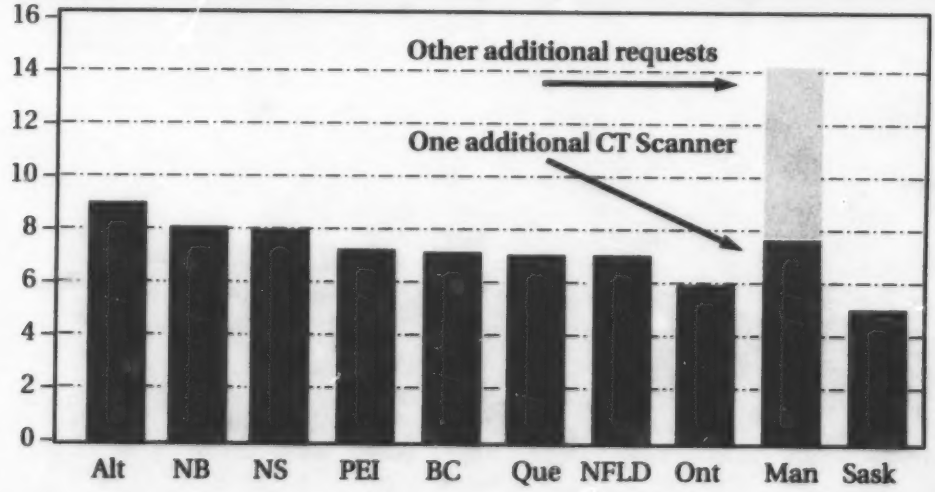
1. Costs include all diagnostics, radiology, nuclear medicine, diagnostic ultrasound, CT Scan, MRI.

2. Limited protocols. No outcome evaluation. (e.g. less than 43% of 1989 MRI referrals appropriate)

Source: Dr. Douglas MacEwan

The chart above shows the explosion in total medical imaging costs in hospitals and private laboratories that has occurred in Manitoba. Over a twelve year period, these costs have increased by about 325%. There is simply no evidence that there has been any commensurate improvement in health outcomes.

CT Scanners
Per Million Population



November, 1990

Source: Dr. Douglas MacEwan

Despite the already very rapid growth in these costs and the lack of evidence that these expenditures are resulting in commensurate benefits, Manitoba already has requests to purchase enough additional CT Scanners to ensure that we will have a vastly greater number of these devices relative to our population than any other province in Canada.

The millions of dollars that are already spent on the application of this technology - and the additional millions that would be required were the government to approve all the requests for additional purchases - are dollars that could be possibly better spent on health services for which there are more efficacious outcomes to patients' needs.

The management and effectiveness concerns

The run-away growth in medical imaging costs in Manitoba has occurred without any systematic evaluation of the real value of this technology as it is being used in Manitoba.

There are limited protocols or guidelines for the use of this high technology equipment. And there has been no systematic evaluation of outcomes. Such protocols as do exist have not been reviewed to ensure that the technology is being employed where it should be - where it can make measurable contributions to improved health outcomes.

The evidence we do have suggests that the equipment is not being properly used. A 1989 survey of MRI referrals found that fully 43% of them were inappropriate - that in the best available medical opinion, their use was not justified in those cases.

There are additional concerns that are not strictly related to costs. There are no effective regulatory criteria to protect patients from any possible adverse dosage impacts from the over employment of imaging technology. There may be apparently wide variations in the quality of operations of some imaging equipment, with procedures being repeated as patients move between institutions.

Managing the Problem

In other words - in the case of medical imaging technology, as with many other technological changes in medical treatment - **we have been buying and using the technology, but we have not been managing it either in terms of its impact on health costs or in terms of its impact on health or the quality of health care in Manitoba.**

The Manitoba Imaging Advisory Committee has been appointed to coordinate all imaging health policy on CT and MRI services in Manitoba. This Committee is chaired by Dr. Blake McClarty.

Developing a systematic management approach

As part of our overall efforts to achieve better and more affordable health services in Manitoba, the Health Services Development Fund is providing the financing for an evaluation program to begin the process of establishing protocols for access to the MRI Scanner at St. Boniface General Hospital. The study will relate use of this high cost technology to patient benefits and will focus on appropriate choices among various kinds of imaging technology.

The Effects of Managing Technology

There is no good evidence that limited access to technology has meant increased risks to the health status of Manitobans or Canadians. Effective service will be deemed to be provided if (new) technology is used properly and **only in the circumstances for which their effectiveness has been clearly demonstrated.**

Already a six month evaluation of clinical services at the MRI clinic where protocols are now established, has been distributed to referring clinicians, radiologists and health facility planners. This review has provided important information related to a total of 1,031 examination requests for Manitoba residents and an additional 167 requests for out-of-province residents.

> "Of the in-province requests, 6.5% cases were determined to be inappropriate and were not accepted for examinations. Of the accepted requests, 56% were for studies of suspected brain disorder, 15% for studies of the spine and spinal cord and 20% were for studies of the large joints, predominantly the knee. Over the course of the first six months of clinical service, the waiting list for examination remained stable. The average number of days between the request date and examination date for the 80% of cases which were judged elective ranged between 25 and 35 days".
> (MRI Utilization Report, January to August 1991).

Once again, we will rely on the leadership of the medical profession in establishing these guidelines. We will continue to work to identify problems in quality of operation of this equipment, in order to ensure the best interest of the patient remains the priority.

The need for general standards for applying new technology

The Need for Protocols

In order to ensure that we are using our technology effectively, we need to apply general standards and protocols for technology acquisition. In the case of medical imaging technology - we must weigh its value in terms of patient benefit and ensure that there are clear protocols for its use. Manitoba Health will insist that strict protocols determine the selection, purchasing, introduction and monitoring of any new technologies.

We will work with the medical profession and insist on substantive evidence of patient benefits before new procedures are added to the Medical Fee Schedule. The Manitoba Centre for Health Policy and Evaluation and the College of Physicians and Surgeons have a central role to assist the Ministry in this endeavor.

An additional concern: technology costs are borne by "the system"; technology savings accrue to the service provider

New technologies like medical imaging have very significant costs and these are borne by the health care system - the taxpayers of Manitoba. But there are other technologies that have significantly simplified a variety of medical, diagnostic and testing procedures.

Although these technologies do result in savings by increasing physician or laboratory productivity or reducing costs, these savings normally accrue - not to the system - but to the individual service provider. We will be suggesting to the medical profession that technological savings be taken into account as the Fee Schedule is reviewed. In a similar way, we will be working to identifying savings in the laboratory sector and to ensure that these are captured by the system.

Priority Action:

Provincial Health Information Strategy

Immediate Attention Needed

Manitoba Health is currently undertaking an intensive examination of a report from its Health Advisory Network regarding Health Information Systems.

A Steering Committee chaired by the Deputy Minister of Health will be announced in the near future. The Committee will be given a special mandate to provide a provincial strategy for Health Information Systems and recommend specific implementation actions consistent with the overall strategy.

Conclusion:

"Quality Health for Manitobans - the Action Plan" is a challenge and an opportunity for all parts of the health services system and the community at large - not simply to contain health costs, but to achieve better health services and better actual health for Manitobans.